

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County Quinn Registration District No. 287 File No. 12439
 Township Colony Primary Registration District No. 171 Registered No. 18
 City Hannouville Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

Luella May Davis
 (a) Residence, No. Hannouville Mo. St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 15 - 1924
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
6 6 13 3

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. X
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. V
 10. Date deceased last worked at this occupation (month and year) X 11. Total time (years) spent in this occupation V

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannouville Arkansas

FATHER
 13. NAME Julius J. Davis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

MOTHER
 15. MAIDEN NAME Gertrude Oddy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

17. INFORMANT (ADDRESS) Elyah Davis

18. BURIAL, CREMATION, OR REMOVAL PLACE Removal DATE April 27 1934

19. UNDERTAKER (ADDRESS) none

20. FILED 4-9-34 C. J. Cape Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 7th 1934

22. I HEREBY CERTIFY, That I attended deceased from April 6 - 1934 to _____, 19____
 I last saw h. _____ alive on _____, 19____ Death is said to have occurred on the date stated above, at 3:19 a.m.
 The principal cause of death and related causes of importance were as follows:

Total Pneumonia
 150 108
 Other contributory causes of importance:
 Date of onset Mar 31 - 1934

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

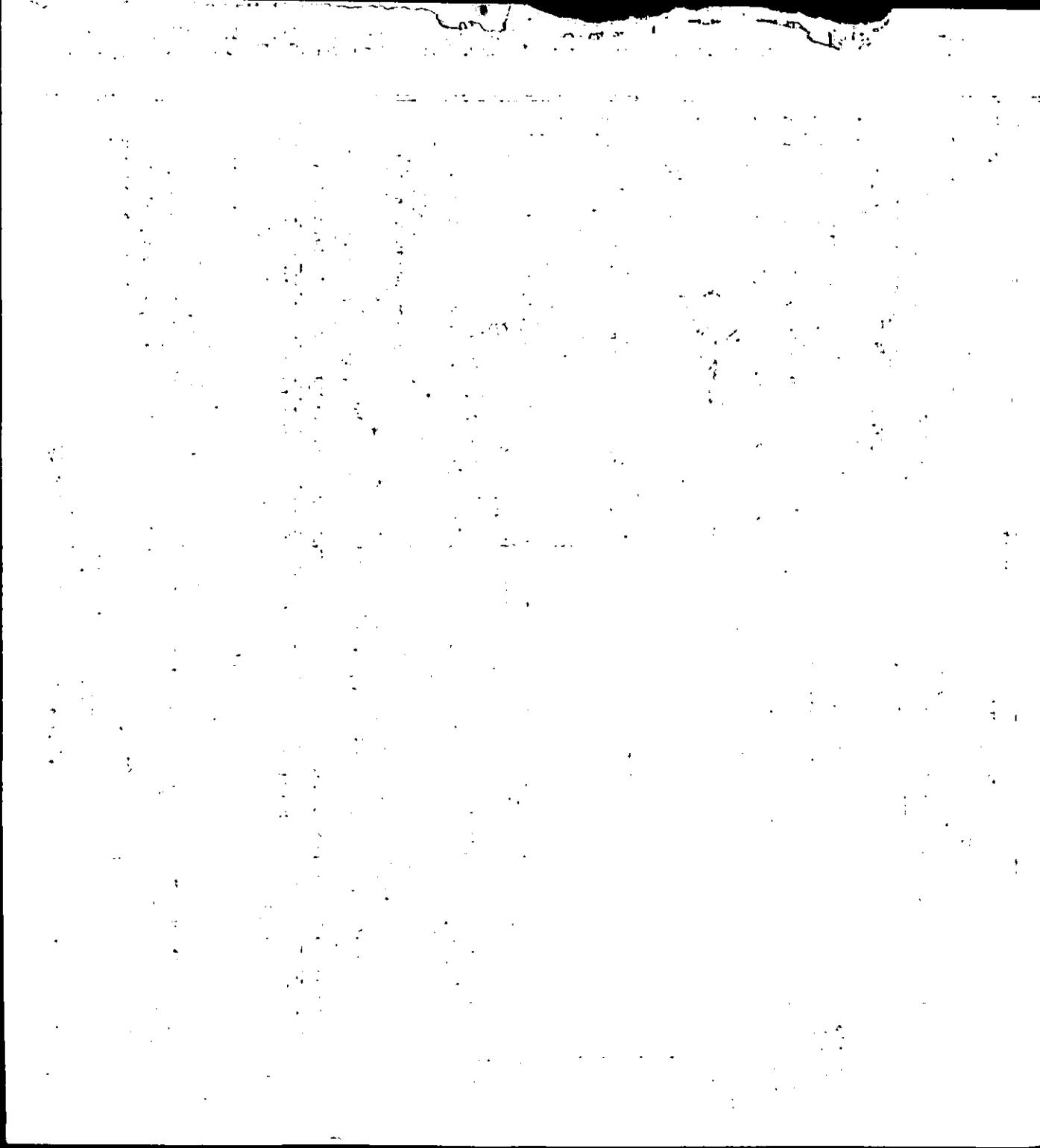
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) June H. Mason, M. D.
 (Address) Hannouville Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



Dunkler

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

12696

Name: Leilla May Davis
Who died at _____ on April 7 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months 6 Days 23

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Lobar pneumonia

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar E. G. base

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 287

Very truly yours,
E. T. McGaugh M.D.

Primary Reg. Dist. No. 4171

Special Agent.

5-12439