

REC'D MAY 11 1939

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

14855
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
(b) Township _____ Primary Registration District No. 2001 Registered No. 285
(c) City SPRINGFIELD (d) Street No. 1411 N. ROGERS St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

HAROLD DE WITT DAVIS
(a) Residence, No. 1411 N. Rogers Springfield, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 20 - 1926
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 12 11 13
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. In school
9. Industry or business in which work was done, as saw mill, bank, etc. School & Home
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

13. NAME Charles H. Davis

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

15. MAIDEN NAME Katherine S. Huntley

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

17. INFORMANT (ADDRESS) Charles H. Davis Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE April 5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Hines & Co. Springfield, Mo.

20. April 3 1939 Chas. A. Berger Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 3 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-30, 1939, to 4-2, 1939
I last saw him alive on 4-2, 1939 Death is said to have occurred on the date stated above, at 6:15 a.m.
The principal cause of death and related causes of importance were as follows:

nephrosis Date of onset 1-30-39

Other contributory causes of importance: myocarditis (chronic)

Name of operation _____ Date of _____
What test confirmed diagnosis? physical exam (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? no
If so, specify: _____
(Signed) Mary Jan Otherton M. D.

(Address) 333 E. McDaniel

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

93C

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed..... *J. B. Higgins*

Licensed Embalmer No. *3858*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

14855-
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1. PLACE OF DEATH

(a) County Springfield Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2001
 (c) City Springfield (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Harold De Witt Davis

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
 (Write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
(12) 22 11 13

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3, 1937
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

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

nephritis (acute)
N. M. D.
930
 Other contributory causes of importance:
Myo Carditis Chronic
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____ Local Registrar _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

14855-
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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001 Registered No. 785-
(c) City Springfield (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Harold De Witt Davis
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) apr 3 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (4-20-1926)

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-20-1916

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 12 22 11 13

The principal cause of death and related causes of importance were as follows:

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Other contributory causes of importance: _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 6-12 1939 Chas A George MD Local Registrar

Name of operation _____ Date of _____

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

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) Mary Jean Letherton M. D. (Address) 333 E. McDaniel

SUPPLEMENTARY

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY