

FILED APR 1 1940

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

11959

Do not use this space.

1. PLACE OF DEATH

(a) County Missouri Registration District No. 655
 (b) Township Union 2 Primary Registration District No. 587A
 or
 (c) City St. Louis Mo (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 18 yrs. mos. da. (f) How long in U. S., if of foreign birth? 18 yrs. mos. da.

2. PRINT FULL NAME

Drusela A. 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

3. SEX F 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-6-1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 5 9

OCCUPATION
 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. Wash. Keeper
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) _____ in this occupation _____
2-15-40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weldonville Tenn

FATHER
 13. NAME John W. Davis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weldonville Tenn

MOTHER
 15. MAIDEN NAME Margaret Hendry

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weldonville Tenn

17. INFORMANT (ADDRESS) Vivian Albritton
St. Louis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Christian Church 2-17-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robinson & Co
St. Louis Mo

20. FILED 3-4-40 D. L. Robinson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15-1940

22. I HEREBY CERTIFY, That I attended deceased from 10 of Feb 1940, to 2-15-1940, 1940

I last saw h. alive on 10 of Feb 1940 Death is said to have occurred on the date stated above, at 5:30 m.

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

heart attack following
a severe attack of
asthma
Date of onset _____

Other contributory causes of importance: asthma

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 _____, 1940

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) J. R. W. and _____, M. D.

(Address) St. Louis Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

K. 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.

3-40-11

112

12.7

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 11959Registration District No. 655Primary Registration District No. 5872

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Pemiscot
 (b) City or town Stagnum
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT
FULL NAMEDressilla A. Davis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if
 alive _____ years

7. Birth date of deceased 9 - 6 - 1874
 (Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|-----------|----------|----------|------|----------------------|
| <u>61</u> | <u>5</u> | <u>9</u> | | _____ min. |

9. Birthplace _____
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 12. Name _____

13. Birthplace _____
 (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 3-18-40 (b) Lo. O. W. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____;
 that I last saw h. _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

- N. M. D. on repeated
 Due to _____
query -

- Due to _____

- Other conditions _____
 (Include pregnancy within 3 months of death)

- Major findings:
 Of operations _____

- Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____
 (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
 (Specify type of place) (e) Years of injury _____

23. Signature J. P. McDaniel M. D. or other) _____
 Address Steele Date signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statisti-
cally.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

11959 (1990)