

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

12779
Do not use this space.

1. PLACE OF DEATH
 (a) County Webster Registration District No. 901
 (b) Township _____ Primary Registration District No. 6209A Registered No. 63
 (c) City Rogersville (d) Street No. 2 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 Leila Holloway Davis
 (a) Residence, No. Rogersville Mo 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William L.
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 24, 1859
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 10 11
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 13 1940
 22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1940 to Mar 13 1940
 I last saw her alive on Mar 13 1940 Death is said to have occurred on the date stated above, at 5:45 p.m.
 The principal cause of death and related causes of importance were as follows:

Paralysis
 Date of onset 1935
 Other contributory causes of importance:
Insanitation

12. BIRTHPLACE (CITY OR TOWN) Webster Co (STATE OR COUNTRY) Missouri
 13. NAME Charles Caldwell
 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 17. INFORMANT Mrs. Ada Delzell (ADDRESS) Rogersville Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE White Oak DATE Mar. 16 1940
 19. FUNERAL DIRECTOR (NAME) Kelley and Ferrell (ADDRESS) Rogersville Mo.
 20. FILED 3-14- 1940 H. P. Passore Local Registrar.

Name of operation no 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? No Date of injury none, 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) J. W. Brad M. D.
 (Address) Rogersville Mo

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

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 important.

1 X18603

RECEIVED

District Health Officer No. 6,

District File Number 420-1185

Date Filed APR 16 1940

SAR

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 H K Kelley

Licensed Embalmer No. 3334

P. O. Address Raymond me

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12779A
Registrar's No. C3

Registration District No. 901 Primary Registration District No. 6209A

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Rogersville Mo.
(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 years, months or days)

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.

3. (a) PRINT FULL NAME

Lelia Halloms Davis

MEDICAL CERTIFICATION

8. (b) If veteran, name war _____

8. (c) Social Security No. Wid

20. DATE OF DEATH, Month Mar day 13 year 1940 hour 6:20 min. AM

I hereby certify that I attended the deceased from May 1940 to Mar 13 1940

4. Sex F

5. Color or race W

6. (a) Single, widowed, divorced, or how long in U. S. A. _____

21. (a) Last saw him alive on Mar 13 1940
21. (b) Date of death occurred on the date and hour stated above Mar 13 1940

6. (b) Name of husband or wife _____

6. (c) Age of b _____

21. (c) Duration of death _____

7. Birth date of deceased _____

(Month)

I hereby certify that I _____

8. AGE:

Years 80 Months 10 Days 11

the last saw him _____ and that death _____ min.

21. (d) Cause of death Paralysis

9. Birthplace _____

(City, town, or _____)

Immediate _____ or foreign country

21. (e) History of cerebral hemorrhage

10. Usual occupation _____

(Year)

21. (f) Due to 5 mile Paralysis of the

11. Industry or business _____

21. (g) Due to Stroke

12. Name _____

21. (h) Other conditions amanition

13. Birthplace _____

(State or foreign country)

21. (i) Due to Stroke

14. Maiden name _____

(State or foreign country)

21. (j) Major findings: Dr. Ungch Hall 18 months

15. Birthplace _____

(State or foreign country)

21. (k) Of autopsy: Both are Deceased

16. (a) Info _____

(b) Δ _____

17. (a) _____

(removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Pl _____

or cremation

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(Registrar's signature)

23. Signature _____

(M. D. or other)

Address _____

Date signed _____

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) (a) Means of injury _____

23. Signature _____

(M. D. or other)

Address _____

Date signed _____

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

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.

SUPPLEMENTAL HISTORY OF DEATH

PHYSICIAN _____

Underline the cause to which death should be charged statistically

original 3-14-1940

S-12779 1940

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.