X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32212

Registration District No. 596 FILED OCT 23 1940 Primary Registration District No. 5552 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson Mt Osage
(b) City or town Sibley (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sibley Mo (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Sibley Mo. (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 Frances Cleo Davis
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 10 (Day) 1893 (Year)

8. AGE: Years 47 Months 1 Days 18 If less than one day hr. min.

9. Birthplace Carthage (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation at home 1
11. Industry or business 1
FATHER
12. Name Miles E. Davis
13. Birthplace Black Hawk (City, town, or county) Iowa (State or foreign country)
MOTHER
14. Maiden name Mary H. Smith
15. Birthplace Ottumwa (City, town, or county) Iowa (State or foreign country)
16. (a) Informant Mrs. Dorothy Kinacke
(b) Address Sibley, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/30 (Month) (Day) (Year)
(c) Place: burial or cremation Sibley Cem.
18. (a) Signature of funeral director George C. Carson
(b) Address Independence Mo
19. (a) Sep 29-40 (Date received local registrar) (b) John W. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 year 1940 hour 3 minute 45 A.M.
21. I hereby certify that I attended the deceased from Oct. 1, 1940, 1940, to Sept 28, 1940, that I last saw her alive on Sept 28, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia	
Due to Carcinoma	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury 2
23. Signature L. W. Higgins (M. D. or other) DO
Address Buckner Mo Date signed 9/28/40

(Licensed Embalmer's Statement on Reverse Side)

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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. Ralph E. Miller

Licensed Embalmer No. 4124

P. O. Address. Independence, Mo.

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32212

Registration District No. 396 Primary Registration District No. 5552 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Ft Osage
(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 years, months or days)
In this community

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 Frances Cleo Davis
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days 18 If less than one day hr. 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 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.

	Duration
Immediate cause of death Hypostatic Pneumonia	
Due to Carcinoma	
Due to Cervical Carcinoma of Uterus	2 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

48

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY