No. 2
-10-39
17-39
X21492

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. 35709

Registration District No. 470 — Primary Registration District No. 5633 — Registrar's No. 135

**1. PLACE OF DEATH:**

(a) County: Lawrence

(b) City or town: Mount Vernon, Twp 3
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 536 days (Specify whether years, months or days)
In this community 536 days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Mississippi

(c) City or town: Wyatt
(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: Inez Davis

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: Black

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: July (Month) 4th (Day) 1923 (Year)

8. AGE: Years 17 | Months 3 | Days 26 | If less than one day _____ hr. _____ min.

9. Birthplace: Hollywood (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation: Student

11. Industry or business: 1

FATHER
12. Name: Jim Davis
13. Birthplace: Tallulah (City, town, or county) Louisana (State or foreign country)

MOTHER
14. Maiden name: Doris Feenches
15. Birthplace: Crystal Springs, (City, town, or county) Missi. (State or foreign country)

16. (a) Informant: E. McMichael, Record Clerk
(b) Address: Missouri State Sanatorium

17. (a) Charleston Mo (Burial, cremation, or removal) (b) Date thereof: Oct 30-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Charleston, Mo

18. (a) Signature of funeral director: Leo Barr
(b) Address: Mt Vernon Mo

19. (a) 10-30-40 (Date received local registrar) (b) P. A. HOLMES (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 30th year 1940 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from May 13, 1939 to October 30th, 1940 that I last saw her alive on October 29th, 1940 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pulm. T.B. | 2 yrs |
| Due to: | |
| 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: _____

23. Signature: Paul H. Wedin (M. D. or other)
Address: Mt Vernon, Mo Date signed 10-30-40

(Licensed Embalmer's Statement on Reverse Side)

## 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 George B Orr

Licensed Embalmer No. 946

P. O. Address Mt Vernon Iro

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

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