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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILLED NOV 21 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35130

Registration District No. 1384

Primary Registration District No. 4227

Registrar's No.

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

1. PLACE OF DEATH

(a) County Newell

(b) City or town West Plains, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Christa Hogan Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days) 0

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County Newell

(c) City or town West Plains (If outside city or town limits, write "RURAL") Mo

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Marye Juanita Davis

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 9 day 12 year 1941 hour 6 minute 50 P.M.

4. Sex 71 5. Color or race W

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

6. (b) Name of husband or wife Newell Davis 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased July 6 - 1906  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 8, 1941 to Sept. 12, 1941, that I last saw her alive on Sept. 12, 1941, and that death occurred on the date and hour stated above.

8. AGE: 35 Years 2 Months 6 Days If less than one day hr. min.

Immediate cause of death Cancer of lungs ✓  
Cancer of Breast

Due to

Due to

9. Birthplace Newell Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name D. E. Langston

13. Birthplace Newell Co., Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Burns

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

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.

16. (a) Informant Newell Davis

(b) Address West Plains, Mo.

17. (a) 13 (Burial, cremation, or removal) (b) Date thereon 9-14-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Robert M. ...

(b) Address West Plains, Mo.

19. (a) 9-14-41 (Date received local registrar) (b) Vida W. SIMONS (Registrar's signature)

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) (e) Means of injury

While at work?

23. Signature W. H. ... (M.D. or other)  
Address West Plains, Mo. Date signed

347 (Licensed Embalmer's Statement on Reverse Side)

Hagan

RECEIVED

District Health Officer No. 5,

District File Number 11412053

Date Filed \_\_\_\_\_

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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..... D. D. Roberts.....

Licensed Embalmer No. 3432.....

P. O. Address West Haven.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35138  
Registrar's No. \_\_\_\_\_

Registration District No. 384

Primary Registration District No. 4227

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains  
(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 NAME Madys J. 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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 6 1906  
(Month) (Day) (Year)

8. AGE: Years 35 Months 2 Days \_\_\_\_\_ (If less than one day)  
min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cancer of Liver  
Cancer of Breast

Due to \_\_\_\_\_  
Due to (Cancer of Breast)

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 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) Means of injury \_\_\_\_\_

23. Signature [Signature] \_\_\_\_\_ (D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

