

S. No. 2  
-11-10-39  
-5-17-39  
-I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

2991

FILED JAN 31 1941 274

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 6261

Registrar's No. 8

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Libbourn (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether)

In this community About 2 years (years, months or days)

8. (a) PRINT FULL NAME Robert Davis

8. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Louisa Davis

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

7. Birth date of deceased About 1954  
(Month) (Day) (Year)

8. AGE: Years About 87 Months Days If less than one day hr. min.

9. Birthplace unk (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Farm Labor

11. Industry or business

MOTHER FATHER { 12. Name unk

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

14. Maiden name unk

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

16. (a) Informant Jim Davis

(b) Address Libbourn Mo R. 1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Portageville, Mo

18. (a) Signature of funeral director No

(b) Address

19. (a) Dec. 23, 1941 (Date received local registrar) (b) Richardson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Libbourn Rural (If outside city or town limits write "RURAL")

(d) Street No. Route 1 (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27  
year 1941 hour 8:20 minute P. 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 No medical attention from record.  
Senility

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1628  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury 3

23. Signature Richardson (M. D. or other) Corover

Address New Madrid Date signed 12-23-41

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

RECEIVED

District Health Office No. 2,

District File Number 142-08

Date Filed 1-16-42

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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..... *No* .....

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.**