

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

Do not use this space.

17182

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **City 14th St # 2**)

File No. **5464**

Registered No. **5464**

St. _____ Ward _____

2. FULL NAME

Baby Davis

(a) Residence. No. **1756 Webster St.** **21** Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred **1** yrs. **1** mos. **0** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female, negro

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 25, 1927**

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, **9** hrs. or **2** min.

few hours

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **nil**

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **William Davis**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ark.**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mrs. Peterson**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ark.**
(STATE OR COUNTRY)

14. INFORMANT **Ana F. Woodard**
(Address) **City Hospital # 2**

15. FILED **JUN 13 1927** **Max C. Starckoff**
19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25 1927**

17. I HEREBY CERTIFY That I attended deceased from **May 25**, 19**27**, to **May 25**, 19**27** (that I last saw h. or alive on **May 25**, 19**27**, and that death occurred, on the date stated above, at **7:20 p.m.**)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Infant
159

CONTRIBUTORY (SECONDARY)

161A

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(Signed) **J. S. ...**, M. D.
, 19 (Address) **City Wash: Mo**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **POTTERS FIELD.**

DATE OF BURIAL

6-16-1927

20. UNDERTAKER

ADDRESS

P. Weston 2945 Stanton

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.

