

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

Do not use this space.

35516

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **10705**

Township.....

Primary Registration District No. **1003**

Registered No.

City..... *St Louis* (No. *2008*..... *Franklin*.....) St. (Ward)

2. FULL NAME..... *Lena Davidson*

(a) Residence. No. St., *M* Ward. (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

Osacar Davidson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 15 1854*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 3 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *at Home*

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Sweden*

10. NAME OF FATHER *M^r Johnson*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs Lizzie Belmont* (Address) *2012 W Franklin*

15. FILED *NOV 29 1927* *Mau & Starckoff* REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 28 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 1927* to *Nov 28 1927* that I last saw her alive on *Nov 28 1927*, and that death occurred, on the date stated above, at..... *8:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
13! (duration) *2* yrs. mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF..... WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) *Fred Wm Taylor*, M. D. *11/29 1927* (Address) *2037 Franklin*

*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 *Memorial Park* DATE OF BURIAL *12-1 1927*

20. UNDERTAKER *Arthur J Donnelly* ADDRESS *2039 Wash St*

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.

Wm. T. Barber

21st & Franklin —