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

Do not use this space.

3143

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St Louis Mo (No. 3914 St Louis Ave St. ..... Ward)

File No. .....

Registered No. 761

2. FULL NAME George W Davison

(a) Residence. No. 3914 St Louis Ave St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	61	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Postal Employe
(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)

PARENTS
10. NAME OF FATHER Theron Davison
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Penn
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Dont know

14. INFORMANT Maude Davison
(Address) 3914 St Louis Ave

15. FILED JAN 28 1928, 19..... Mark Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug. 4 1926, to Jan 18 1928 that I last saw h. alive on Jan 18 1928, and that death occurred, on the date stated above, at 10 30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis.

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93C (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic nephritis.
(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical.
(Signed) L P Gay M.D
, 19 (Address) 908 Beaumont Bldg.

*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	DATE OF BURIAL
Valhalla	Jan 22 1928
20. UNDERTAKER	**ADDRESS**
Hy Leidner Und Co	1417 N. Market 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.