

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

Do not use this space.

15245 14978

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis**, (No. **Home for the Aged**) St. _____ Ward _____

2. FULL NAME

Adeline Davis
 (a) Residence. No. **3400 Grand Blvd** St. **16** 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dont know

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
 About 76

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.....

BIRTHPLACE (CITY OR TOWN)..... **Missouri**
 (STATE OR COUNTRY)

10. NAME OF FATHER Dont know

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT **Walter Benzal**
 (Address) **2400 St. Francis St. S. E. 13th**

15. APR 16 1928 **Max E. Standiford**
 FILED 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 16 1928**

17. I HEREBY CERTIFY, That I attended deceased from **March 11**, 19**28**, to **April 16**, 19**28**, that I last saw him alive on **April 15**, 19**28**, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Infection gangrenous type
57 (duration) yrs. mos. **16** ds.
9813
21 **Diphtheria Mellitus** (SECONDARY) (duration) yrs. mos. **6** ds.

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) **W. Swera**, M. D.
4/16, 19**28** (Address) **3165 S. Grand**

*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**

S. S. Peter and Paul Cemetery **Apr 17 1928**

20. UNDERTAKER **ADDRESS**

J. H. Gibson & Sons, Inc. **2842 McManure**

K. 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.

THIS IS A PERMANENT RECORD

