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

Do not use this space.
7969

1. PLACE OF DEATH

County: St Louis
Township: Central
City: Richmond Ht, Mo St Mary's Hosp.
Registration District No.: 1170
Primary Registration District No.: 6248 H
File No.:
Registered No.: 36
St. Ward)

2. FULL NAME James Robert Davis

(a) Residence. No. 3730 Blair Ave. St. Ward. St Louis, Mo
(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)
M	W	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Addie Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5, 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	42	6	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Structural Iron
(b) General nature of industry, business, or establishment in which employed (or employer): Worker
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Caseyville
(STATE OR COUNTRY) Ky

PARENTS
10. NAME OF FATHER James Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Bell Cardwell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ky

14. INFORMANT Addie Davis
(Address) 4227 Aubert Ave.

15. FILED 2/7, 19 29 C. L. Jensen REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/6 19 29

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11 30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental Traumatism by fall (fell from elevator 15-20 ft. high)
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fractured skull + internal injuries
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 6800 Manchester St Louis Mo.
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) John A Connell, M. D
, 19 (Address) Coroner, St Louis Co.

*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 Calvary Cemetery — DATE OF BURIAL Feb 9 19 29
20. UNDERTAKER Strodt & Connell — ADDRESS 4600 Natl. Bridge Rd

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: St. Louis — Registration District No. 1170 — File No.
Township — Primary Registration District No. 62-488 — Registered No. 36
City: Ft. Leighton (No. ..... St. ..... Ward)

2. FULL NAME: James Robert Davis

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5-1887

7. AGE: Years 41 — Months 6 — Days 1 — If LESS than 1 day, ... hrs. or ..... min.

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/6 19 29 C. L. Jensen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-6 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... 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) ....., M. D
, 19 (Address)

*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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

...VE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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