

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Townshp..... Primary Registration District No. **1003**  
 City St. Louis (No. 4017, St. Ferdinand St.          Ward)

File No. **19780**  
 Registered No. **5391**

**2. FULL NAME**

Annie Davis  
 (a) Residence No.          St. 11 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 <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nicholas Davis</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 18 1856</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.	
<u>abt.</u>	<u>73</u>	<u>-</u>	<u>-</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at Home</u> (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) <u>Ireland</u>					
10. NAME OF FATHER <u>John O'Brien</u>					
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>					
12. MAIDEN NAME OF MOTHER <u>Unknown</u>					
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>					
14. INFORMANT <u>Kathryn A Davis</u> (Address) <u>4017 St Ferdinand</u>					
15. FILED <u>MAY 15 1929</u> <u>W. C. Parker</u> REGISTRAR					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/13 1929

17. I HEREBY CERTIFY That I attended deceased from May 11 1929 to May 13 1929 that I last saw him alive on 5/13 1929 and that death occurred, on the date stated above, at 11 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Myocarditis  
 (duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None  
 (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) Joseph Schaffer M.D.  
5/14 1929 (Address) 333 University Club

\*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 DATE OF BURIAL 5-16 1929

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 West 47

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

15-13-29 262

100 Schafers  
Reviews at 2 hrs

Jep 1130  
12-1