

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

Do not use this space.

26432

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... (No. *City Hospital # 2*)

Registration District No. **791**  
**1003**  
Primary Registration District No. *City Hospital # 2*

File No.....  
Registered No. **7687**  
St. .... Ward)

**2. FULL NAME**

*Billy Davis*  
(a) Residence. No. *3414 Belle St.* St. *21* 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *Male*  
4. COLOR OR RACE *Col*  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7/11* 19 *29*

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

17. I HEREBY CERTIFY, That I attended deceased from *7/11/1929*, 19... to *7/11*, 19... that I last saw him alive on *7/11*, 19... and that death occurred, on the date stated above, at *9:40 P.M.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *7-11-29*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or mfa.  
*6 hrs 20 minutes*

*Asphyxia (Ballida)*  
*161D* (duration) yrs. mos. ds.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Nil*  
(c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) *162* (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo*  
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER *Cheston Davis*

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? \_\_\_\_\_

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

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *H. W. Luthers* M. D.

12. MAIDEN NAME OF MOTHER *Jeanette Davis*

*7/12. 19 29* (Address) *City Hospital # 2*

\*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.

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

14. INFORMANT *W. G. Gentry*  
(Address) *City Hospital # 2*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **POTTERS FIELD,** DATE OF BURIAL *7-25-1929*

15. FILED *JUL 25 1929* *W. C. Farley*  
REGISTRAR

20. UNDERTAKER *R. Aston, 2945 Lawton*  
ADDRESS

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.

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

