

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

Do not use this space.

35707

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... *St. Louis* (No. *2845<sup>a</sup> base a*)

File No. ....

Registered No. **10499**

St. .... Ward)

**2. FULL NAME** *Katherine Davis*

(a) Residence. No. .... St. *20* 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. da.

How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*about 61*

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

10. NAME OF FATHER *John Comer*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Martin Davis*  
(Address) *2845<sup>a</sup> base a*

15. *OCT 25 1929* *Max C. Frank*  
FILED 1929 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 24 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:  
*Acute Peritonitis following ruptured intestines.*

CONTRIBUTORY (SECONDARY) *114* (duration) *129* yrs. *1238* mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *J. J. [Signature]*  
*10/25.29* (Address) *2845<sup>a</sup> base a*

\*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 *10-26 1929*  
ADDRESS *2039 Ward St*

20. UNDERTAKER *Arthur J. Romey*

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.

