

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

Do not use this space.

10483

**1. PLACE OF DEATH**

County..... Registration District No. 701  
Township..... Primary Registration District No. 1008  
City St. Louis (No. 3027 Morgan)

File No. ....  
Registered No. 2471  
St. .... Ward)

**2. FULL NAME**

Louis Davis  
(a) Residence. No. 3027 Morgan St., 21 Ward. (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 <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 13, 1929</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.	
		<u>6</u>	<u>26</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer					
9. BIRTHPLACE (CITY OR TOWN) <u>St. Louis</u> (STATE OR COUNTRY) <u>Missouri</u>					
PARENTS	10. NAME OF FATHER <u>Ben Davis</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>				
	12. MAIDEN NAME OF MOTHER <u>Mabel Harper</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>				
14. INFORMANT <u>Ben Davis</u> (Address) <u>3027 Morgan</u>					
15. FILED <u>May 1930</u> REGISTRAR					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 9, 1930  
17. No Physician in Attendance  
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 4:30 a.m.  
THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Gastro Enteritis  
11 B (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 11 B B (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? no  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. W. Jones M.D.  
3/10 19 30 (Address) Dep. Coron  
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, HOMICIDAL.  
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Crematorium DATE OF BURIAL March 1930  
20. UNDERTAKER Cater's Funeral Home ADDRESS 4107 Lindbergh

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.

MARGIN RESERVED FOR BIRDING

