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

Do not use this space.

17334

File No.
Registered No. 4377

1. PLACE OF DEATH

County
Registration District No. 791
Township
Primary Registration District No. 1003
City St. Louis (No. St. Mary's Infirmary St. Ward)

2. FULL NAME Charles H. Davidson

(a) Residence. No. 1023 N 18th 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

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Davidson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2 - 1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	44	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Smithman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Terminal R.R. Assn

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

PARENTS

10. NAME OF FATHER Alfred T. Davidson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Elizabeth Davidson
(Address) 1023 N. 18th St.

15. FILED May 2, 19 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-1- 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1930, to 5-1-, 1930, that I last saw him alive on 4-30-, 1930, and that death occurred, on the date stated above, at 12:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bilateral Pyo-Nephrosis
131
133A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Nephritis Chr Parenchy
Malum (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? At his home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Cytoscopic Exam
(Signed) Dr P.D. Blackburn, M.D.
, 19 (Address) 3115 So Grand Ave

*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 May 3 1930

20. UNDERTAKER Cullinane Bros.
ADDRESS 1710 N Broadway

Nos. 12, 13, 31: 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.