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.

# 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 ~~1005~~ File No. 7262

Township ..... Primary Registration District No. ..... Registered No. 1572

City ST. LOUIS MO. (No. 5076 EASTON AVE. St. ..... Ward)

2. FULL NAME ELMER FREEMONT DAVIS.

(a) Residence. No. 5076 EASTON AVE. St., 6 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| MALE. | WHITE. | WIDOWED. |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WIIFORD.DAVIS.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/20/1869

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 61 | 9 | 16 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work DRUGGIST.

(b) General nature of industry, business, or establishment in which employed (or employer) RETIRED.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) MT. PLEASANT. 2
(STATE OR COUNTRY) IOWA.

PARENTS

10. NAME OF FATHER JAMES H. DAVIS.

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

12. MAIDEN NAME OF MOTHER ELIZABETH LINN.

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

14. INFORMANT Elizabeth Munfell
(Address) 5076 Easton Ave

15. FEB -7 1931 FILED ..... 19 ..... C Stanley REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-6-1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1931, to Feb 6, 1931, that I last saw him alive on Feb 6, 1931, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Lobar Pneumonia
108

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY) 108

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF 1

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. H. Walton, M. D.

, 19 (Address) 2945 Franklin

*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 | DATE OF BURIAL |
|---|---|
| Valhalla Cem | 2/10/31 19 |
| 20. UNDERTAKER | ADDRESS |
| Provosh Med Co | 3710 N Grand |