

**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**
1003

Township.....

City Registration District No. **City Hospital #2**

City **St. Louis, Mo** (No.)

File No. **11687**

Registered No. **2912**

St. Ward

2. FULL NAME

(a) Residence. No. **3623 MARKET** St. **18** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **45** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

WIDOWED

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

UNKNOWN

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

5-7-1871

7. AGE

59

9

26

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **COMM. LABOR**
(b) General nature of industry, business, or establishment in which employed (or employer). **Construction work.**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER

EDMOND DAVIS

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **UNKNOWN '31**

12. MAIDEN NAME OF MOTHER

ELLEN STABLES

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **UNKNOWN**

14.

INFORMANT

ANGERTRUDE CREATH
(Address) **CITY HOSPITAL #2**

15.

FILED

Max O. Starker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-3-1931**

17.
I HEREBY CERTIFY, That I attended deceased from **2-25-1931**, to **3-3-1931**, that I last saw him alive on **3-3-1931**, and that death occurred, on the date stated above, at **4:00 A.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

BRONCHO-PNEUMONIA
11A (NON-TUBERCULAR)
107A (duration) yrs. mos. **5** ds.
CONTRIBUTORY INFLUENZA (PULMONARY)
(SECONDARY) (duration) yrs. mos. **14** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **AT HOME**
DID AN OPERATION PRECEDE DEATH. **NO** DATE OF.....
WAS THERE AN AUTOPSY **YES**
WHAT TEST CONFIRMED DIAGNOSIS **Autopsy - CLINICAL-LAB**
(Signed) **Henry W. Hampton**, M. D.
3-3-1931 (Address) **City Hosp. #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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Washington Park Ceme **3/7-1931**

20. UNDERTAKER

ADDRESS

Peoples' Aid Company **Franklin Ave.**

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.

