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.

L. A. James
REC'D DEC 12 1938

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

37603
Do not use this space.

1. PLACE OF DEATH
(a) County 1 Registration District No. 791
(b) Township 2 Primary Registration District No. 1002 Registered No. 9930
(c) City St. Louis, Mo. (d) Street No. US Marine Hospital, 3640 Marine Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred X yrs. 1 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Leo Davis
(a) Residence, No. St. NR Grand Chain, Ill.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 29, 1889
7. AGE: Years 49 | Months 6 | Days 17 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Watchman
9. Industry or business in which work was done, as saw mill, bank, etc. on River steamer.
10. Date deceased last worked at this occupation (month and year) Sept. 5, 1938
11. Total time (years) spent in this occupation Unknown

12. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ill. 1

FATHER
13. NAME Jeff Davis
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ill. 1

MOTHER
15. MAIDEN NAME Martha Linzy
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) ~~Ill.~~ KENTUCKY 1

17. INFORMANT (ADDRESS) Clinical Record, U.S. Marine Hospital, St. Louis, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE GRAND CHAIN ILL DATE 11-19 1938

19. FUNERAL DIRECTOR (ADDRESS) Albert H. Hoppe, Inc. 4700 Washington Blvd.

20. FILED NOV 17 1938 J. F. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 16, 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1938, 19, to Nov. 16, 1938, 19
I last saw him alive on Nov. 16, 1938, 19 Death is said to have occurred on the date stated above, at 7:15 A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Tuberculosis, pulmonary, chr. far advanced.	Unknown

Other contributory causes of importance:

Hernia, ventral, post operative.	Unknown

Name of operation None Date of
What test confirmed diagnosis Clinical and laboratory Was there an autopsy? no
No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) C. Y. Bailey, Surg. (R) USPHS, M. D.
(Address) US Marine Hospital, St. Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3575

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)