

REC'D MAR 13 1939

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

5209  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Mo. Registration District No. 1  
 (b) Township St. Louis Mo. Primary Registration District No. St. John's Hospital Registered No. 1902  
 (c) City St. Louis Mo. (d) Street No. St. John's Hospital 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 120 OTHO F. DAVIS

(a) Residence, No. 3617 Paris Ave. St. 10  
 (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) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Josephine Davis  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 10, 1867  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
71 2 18

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk  
 9. Industry or business in which work was done, as saw mill, bank, etc. Wabash R. R.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fulton Missouri

FATHER  
 13. NAME William Davis  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

MOTHER  
 15. MAIDEN NAME Emily Nichols  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Mrs. Josephine Davis 3617 Paris Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla DATE March 1, 1939

19. FUNERAL DIRECTOR (ADDRESS) A. Kron & U. Co. 2707 North Grand St.

20. FILED FEB 28 1939 J. P. Bruleck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 28, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 2-24-39, 1939 to 2-27-39, 1939  
 I last saw him alive on 2-27-39, 1939. Death is said to have occurred on the date stated above, at 5.20 A.M.  
 The principal cause of death and related causes of importance were as follows:

Cerebral Thrombosis Date of onset \_\_\_\_\_  
 Other contributory causes of importance Nephritis (Chronic Interstitial) Hypertension

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? Alison Was there an autopsy? 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. A. White M. D.  
 (Address) 114 W. Theatre Bldg.

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.

STATEMENT BY LICENSED EMBALMER

I, Paul H. Krollenberg, Licensed Embalmer No. 9631

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 Paul H. Krollenberg

Licensed Embalmer/No. 9631

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