

REC'D MAY 10 1939

 MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS 791  
 CERTIFICATE OF DEATH 1008

13064

Do not use this space.

## 1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. .... Registered No. **3406**  
 (c) City **St. Louis** (d) Street No. **Homer Phillips 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 **25** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **James Davis**

(a) Residence, No. **3444 Leclde** St. **21** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 23, 1895**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**43 5 13**

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Texas**

13. NAME **James Davis**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Tennessee**

15. MAIDEN NAME **Sarah Bledsoe**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Texas**

17. INFORMANT **Evelyn Hilliard**  
 (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL PLACE **National Cem.** DATE **7/12**, 19**39**

19. FUNERAL DIRECTOR (NAME) **R. M. C. GREEN**  
 (ADDRESS) **3517 LACLEDE AVE**

20. FILED **APR 12 1939** **J. B. ...** Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 6**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **April 5**, 19**39**, to **April 6**, 19**39**

I last saw him alive on **April 6**, 19**39** Death is said to have occurred on the date stated above, at **10:10am**.

The principal cause of death and related causes of importance were as follows:

**Lobar pneumonia**Date of onset **4/5/39**

Other contributory causes of importance

Name of operation ..... Date of .....  
 What test confirmed diagnosis? **clinical** Was there an autopsy? **yes**

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? .....  
 If so, specify **AD Lyman**, M. D.  
 (Signed) **Evelyn Hilliard**  
 (Address) **2601 N Whittier**

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 1173

P. O. Address 3517 Sacloade Ave

**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.)**

**If this body is not embalmed, above space should be left blank.**