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.

REC'D JUL 12 1939

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

20273

Do not use this space.

1. PLACE OF DEATH

(a) County 3 Registration District No. 791

(b) Township 1 Primary Registration District No. 1003 Registered No. 5117

(c) City ST. LOUIS MO. (d) Street No. En Route City 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 1932 GEORGE W. DAVIDSON.

(a) Residence, No. 1520 N 18TH ST = REAR = St. 26
(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): WIDOWER.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEP 13TH 1866

7. AGE: YEARS 72 | MONTHS 8. | DAYS 22 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. PORTER.
9. Industry or business in which work was done, as saw mill, bank, etc. HARNESS SHOP.
10. Date deceased last worked at this occupation (month and year) MAY 20/1939
11. Total time (years) spent in this occupation 5 YRS

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS MO

FATHER

13. NAME CHARLES DAVIDSON. 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) SCOTLAND. 4

MOTHER

15. MAIDEN NAME DONT KNOW. 9
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " " "

17. INFORMANT (ADDRESS) George H Davidson 4321 LINTON AVE

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE JUNE 7TH 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) BROCKLAND UND. CO 1827 HOGAN. STR.

20. FILED JUN 7 1939 J. F. Brebeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/4, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 5 p.m.

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

Date of onset

Cerebral Apoplexy

Other contributory causes of importance:

Name of operation ..... Date of ..... No

What test confirmed diagnosis? ..... Was there an autopsy?

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) Joseph M. Quinn, M.D.

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

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 John B. Brockland

Licensed Embalmer No. 93

P. O. Address St. Louis Mo.

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.