

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.

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 5743

1. PLACE OF DEATH: 1003

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1400 Semple 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 50 Years

3. (a) PRINT FULL NAME Annie Davis 120

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Max Davis

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 22 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>10</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace Poland
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Abraham Goldman

13. Birthplace Poland
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta Bruba

15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address 4715 McPherson

17. (a) Burial (b) Date thereof 6/30/1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director H. B. Berger

(b) Address 4715 McPherson

19. (a) JUN 28 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")

(d) Street No. 1400 Semple
(If rural, give location)

(e) If foreign born, how long in U. S. A. 50 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 28 TH
year 1939 hour 6:20 minute _____ A.M.

21. I hereby certify that I attended the deceased from Aug _____, 1938, to June _____, 1939;
that I last saw her alive on JUNE 26TH, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYOCARDITIS

Due to CHRONIC GLOMERULI NEPHRITIS

Due to _____

Other conditions _____
(Includes pregnancy within 3 months of death)

Major findings: [Signature]

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature [Signature] (M. D. or other) Dr.

Address 4386 LINDELL BLVD Date signed 6/28/39

Duration of illness _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

H. I. Berger

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

working under my personal supervision.

Signed.....



Licensed Embalmer No..... **1597**

P. O. Address.....

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.