

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
 (b) City or town St. Louis
 (c) Name of hospital or institution: St. Louis Children's Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 In this community 30 days
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis Mo. (Web. Groves)
 (If outside city or town limits, write "RURAL")
 (d) Street No. 979 Newport
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 11 day 17
 year 39 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 11-14, 1939, to 11-17, 1939
 and that death occurred on the date and hour stated above.
 that I last saw her alive on 11-17, 1939

Immediate cause of death Septicemia
meningitis
multiple abscesses
 Due to Salmonella
dehydration
 Due to Bacterial Dysentery, Non-calculous
Bilateral suppurative Otitis media

Duration
1 week
?
3 weeks
2 days
3 weeks
4 days

Other conditions (include pregnancy within 3 months of death)
abscesses caused by
 Major findings: septicemia B. Cole
 Of operations _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy 133a

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) _____
 (a) Means of injury _____

23. Signature R. D. Leather (M. D. or other)
 Address 504 South Kensington Date signed _____

3. (a) PRINT FULL NAME KAREN DAVIS
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10-19-39
 (Month) (Day) (Year)

8. AGE: Years _____ Months # Days 28 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name KAREN DAVIS

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

14. Maiden name Kathryn Bush

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

16. (a) Informant's own signature [Signature]
 (b) Address 504 South Kensington

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cap Hill Cem.

18. (a) Signature of funeral director [Signature]
 (b) Address 331 E. Big Bend Webster

19. (a) NOV 18 1939
 (Date received local registrar) [Signature]

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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

L. R. Cooper

Licensed Embalmer No. *3633*

P. O. Address. *2317 Lafayette*

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.