

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 475  
475

Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (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:  
4315 N. Broadway  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 17 (Specify whether  
 In this community 50 yrs. years, months or days)

3. (a) PRINT FULL NAME Samuel Davis 1208. (b) If veteran, name war Nil 3. (c) Social Security No. Nil4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Sarah Davis 6. (c) Age of husband or wife if alive Nil years7. Birth date of deceased July 26 1860  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
79 5 20 hr. min.9. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)10. Usual occupation Retired11. Industry or business Moving Co. 912. Name Unknown 913. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Stella Hodde(b) Address Millstadt St.17. (a) Burial (b) Date thereof: Jan. 17 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Vahalla Cemetery18. (a) Signature of funeral director Chudmeyer & Sons(b) Address 3934 N. 20th St.19. (a) JAN 17 1940 (b) \_\_\_\_\_  
(Date received for registration) (City, town, or county)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 9  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4315 N. Bdwy.  
 (If rural, give location)  
 (e) 77 years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 16  
year 1940 hour 7:45 minute A. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Senile Degeneration  
Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
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 \_\_\_\_\_23. Signature Joseph Hodde (as D. or other) \_\_\_\_\_Address Millstadt St. \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 6-17-39  
FORM 1 (1938)

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.

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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.....

*NOT EMBALMED*, Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**