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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 25 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23928

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 6373

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days / (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland N.R.
(If outside city or town limits, write "RURAL") O

(d) Street No. 909 Mound St
(If rural, give location)

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

3. (a) PRINT FULL NAME Della 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 Peter J. Davis

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

7. Birth date of deceased July 24 1873 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
67	—	5	hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant George T. Davis
(b) Address 909 Mound St Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave

19. (a) JUL 29 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29, year 1940 hour 8:10 minute A.M.

21. I hereby certify that I attended the deceased from July 27, 1940 to July 29, 1940 that I last saw her alive on July 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Not done

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature Samuel Wallace Jr (M. D. or other) M.D.
Address 1515 Lafayette Date signed 7/29/40

(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.....

Licensed Embalmer No. 3245

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, fact should be so stated above.