

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME John R. Davis  
8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 6. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose Davis 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Jan. 16th 1879  
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Plumber

11. Industry or business Davis Plumbing Co.

12. Name John R. Davis

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

14. Maiden name Sarah Hutchinson

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

16. (a) Informant Rose Davis  
(b) Address Commerce Mo.

17. (a) Burial (b) Date thereof 9-21-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director Kriegshauser Mortuar  
(b) Address 4228 So. Kingshighway Blvd.

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County \_\_\_\_\_  
(c) City or town Commerce  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 18th  
year 1940 hour 5:30 minute P.M. M.

21. I hereby certify that I attended the deceased from Aug. 26  
1940, to Sept. 18 1940  
that I last saw him alive on Sept. 18 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis non Epidemica  
Due to Summe Cerebri Luetica

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?  
\_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature P. C. Herchumson (M. D. or other) \_\_\_\_\_  
Address 5000 S Broadway Date signed 9/19/40

Duration 23 days  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SEP 19 1940

Dr. L.C. Hirschenroeder

~~Michigan State~~ 4250  
5000 So Broadway  
1-3

**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 Edmund M. Bennett

Licensed Embalmer No. 3024

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.**