. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED NOV 25 19[illegible]

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36330

Registration District No. 784 Primary Registration District No. 202 Registrar's No. 2063

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 days (Specify whether
In this community 29 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits write "RURAL")
(d) Street No. 4337 Page (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mabel Davis
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex F
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Stephen Davis
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased Oct (Month) 18 (Day) 1909 (Year)

8. AGE: Years 31 Months 0 Days 13 If less than one day hr. min.

9. Birthplace Brownsville (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation House work & Elevator girl
11. Industry or business Department Store
12. Name of father Wm Newberry
13. Birthplace Brownsville (City, town, or county) Tenn (State or foreign country)
14. Maiden name of mother Eliza Carne
15. Birthplace Brownsville (City, town, or county) Tenn (State or foreign country)
16. (a) Informant Robert Koch Hospital Record
(b) Address Koch Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 5 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director F. W. Bruce
(b) Address 100 34 Garrison Ave St L Mo
19. (a) NOV 4 1940 (Date received local registrar) (b) C. R. Myers M.D. Dr P.H. (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1940 hour 5 minute 50 A.M.
21. I hereby certify that I attended the deceased from Oct. 2, 1940, to Oct 31, 1940
that I last saw h[illegible] alive on Oct 30, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	16 Mo
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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 Paul Murphy M.D. (M. D. or other)
Address Koch Mo Date signed 10-31-40

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

William C. McDowell, Registered Apprentice No.

working under my personal supervision.

Signed Wm C McDowell

Licensed Embalmer No. 2114

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.