DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33681

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8639

X28330

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County 28

(c) City or town Berryman, Mo - O/NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Robert Gilbert Davis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 August (Month) 17 (Day) 1889 (Year)

8. AGE: Years	Months	Days	If less than one day
52	2	11	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name Frank Davis

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

MOTHER 14. Maiden name Ida Burns

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

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Potosi, Mo.

18. (a) Signature of funeral director Sparks

(b) Address Potosi Mo

19. (a) 10-30-41 (Date received local registrar) (b) J F Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28 year 1941 hour 8 15 minute P M.

21. I hereby certify that I attended the deceased from Oct. 8, 1941, to Oct. 28, 1941; that I last saw him alive on Oct. 28, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations NO

Of autopsy yes

Duration

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 Gilbert E. Koch (M. D. or other)

Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

8698

8698

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 M. L. Sparks

Licensed Embalmer No. 4236

P. O. Address Edina, Mo.

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—8-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 33681

Registration District No. 791 Primary Registration District No. 1003 Registrar's 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:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Robert L. Davis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 17 1889
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days If less than one day hr. min.

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

10. Usual occupation Unknown

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant Dora Davis

(b) Address Berryman, Mo

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) DEC 5 1941 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 28 year 1941 hour minute 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

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY