

REGISTRATION DISTRICT NO. **318**

PRIMARY REGISTRATION DISTRICT NO. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(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: **Homer G. Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo. 1 day**
(Specify whether
In this community **60 years**
years, months or days)

3. (a) PRINT FULL NAME **William H. Davis**
3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex **male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Alice Davis** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **April 9 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 1 29 hr. min.

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

10. Usual occupation **Nil**

11. Industry or business

12. Name **Joseph Davis**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Bethel Richards**

(b) Address **3142 Marnie Pl.**

17. (a) **Burial** (b) Date thereof **6-11-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Dickson Cem.**

18. (a) Signature of funeral director **Russell Undt. Co.**
(b) Address **2732 Pine Street**

19. (a) **JUN 11 1943** (b) **J. A. Brudek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **002 17 7 10**
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3142 Marnie Place**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **8**, year **1943** hour **1** minute **15 P.** M.
21. I hereby certify that I attended the deceased from **May 7**, 19**43** to **June 8**, 19**43**.
that I last saw him alive on **June 8**, 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypertensive Heart Disease**
Atrial Fibrillation
Pulmonary T. B.
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 **D. E. Smith** (M. D. or other).....
Address **2601 S. Webster** Date signed **6/10/43**

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

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: *Joel Russell*

Licensed Embalmer No. *4112*

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.