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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 19 1943

Registration District No. 218

Primary Registration District No. 1002

Registrar's No. 8852

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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Mo. 21 days
(Specify whether years, months or days)

In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
12

(c) City or town St. Louis 911
(If outside city or town limits, write "RURAL")

(d) Street No. 1419 Hills Terrace
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Kate Belle Davidson

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Edward P 6. (c) Age of husband or wife if alive 26 year

7. Birth date of deceased (Month) (Day) (Year) 8 26 1852

AGE:	Years	Months	Days	If less than one day
<u>87</u>	<u>86</u>	<u>1</u>	<u>11</u> hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Thurman

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

14. Maiden name Unknown

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

16. (a) Informant Jess Lake

(b) Address 1419 Hills Terrace

17. (a) Buried (b) Date thereof 10-9-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Camp

18. (a) Signature of funeral director Cullen & Kelly

(b) Address 1416 N. Taylor

19. (a) OCT 7 1943
(Date received local registrar's certificate)

J. F. Medical
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7,
year 1943 hour 6:20 minute A. M.

21. I hereby certify that I attended the deceased from August
16, 1943 to October 7, 1943;
that I last saw her alive on October 7, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Secondary anemia

Due to undetermined cause

Due to 73

Other conditions (Include pregnancy within 3 months of death) Senility

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)
(c) Means of injury.....
23. Signature Home A. Swetman, M.D.
(M. D. or other)
Address 1515 Lafayette Avenue Date signed 10/7/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

OCT 7 1943

Embalmer's separate Certificate filed

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.....

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.