

Registration District No. **DEC 22 1943**

Primary Registration District No. **1003**

Registrar's No. **10876**

1. PLACE OF DEATH:

(a) County
(b) City or town **Saint Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3655 Blow Street.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
years, months or days

3. (a) PRINT FULL NAME **Nellie Davis.**

3. (b) If veteran, name war
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widowed.**

6. (b) Name of husband or wife **Charles Davis** 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased **December 19th, 1867.**
(Month) (Day) (Year)

8. AGE: **75** Years **11** Months **19** Days If less than one day hr. min.

9. Birthplace **Saint Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House-work**

11. Industry or business

12. Name **Jacob Persinger**

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

14. Maiden name **Unknown**

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

16. (a) Informant **May Stine**

(b) Address **3655 Blow Street.**

17. (a) **Burial** (b) Date thereof **Dec. 10-1943.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn Cemetery.**

18. (a) Signature of funeral director **Legenhein Bros.**

(b) Address **8409 Gravois Ave.**

19. (a) **DEC 9 1943** (b) **J. F. Bredner**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County **000**
(c) City or town **Saint Louis,** (If outside city or town limits, write "RURAL") **12**
(d) Street No. **3655 Blow Street.** (If rural, give location) **9**
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **8th,**
year **1943.** hour **5** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **Nov. 20, 1943 to Dec. 8, 1943**
that I last saw her alive on **Nov. 7, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage, left

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 **J. J. Vallman** (M. D. or other)

Address **3223 B. Blvd. W. St. Louis** Date signed **11/14/43**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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. *W E Morris*

P. O. Address *3360*

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.