

FILED JUN 1 1944

Registration District No. _____

Primary Registration District No. **1000**

Registrar's No. **4784**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo**
(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 **12 days**
In this community **12 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Samuel Herman Davis**

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

4. Sex **Male**
5. Color or race **Wht.**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Nellie Davis**
6. (c) Age of husband or wife if alive **25** years

7. Birth date of deceased **Mar. 25 1892**
(Month) (Day) (Year)

8. AGE: Years **52** Months **1** Days **29**
If less than one day hr. min.

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

10. Usual occupation **Salesman**

11. Industry or business _____

MOTHER FATHER { 12. Name **Nathan D. Davis**

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

14. Maiden name **Jennie Hershberg**

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

16. (a) Informant **Nellie Davis**
(b) Address **1040 Fefferson, McKeesport Pa.**

17. (a) **Removal**
(Burial, cremation, or removal) (b) Date thereof **5/24/44**
(Month) (Day) (Year)

(c) Place: burial or cremation **McKeesport Pa.**

18. (a) Signature of funeral director **Wm. B. Moydell**
(b) Address **1926 Allen Ave.**
19. (a) **MAY 24 1944**
(Date received local registrar) (Registrar's signature) **J. F. Bredech**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **999**
(c) City or town **ST. LOUIS** **36 NR**
(If outside city or town limits, write "RURAL")
(d) Street No. **1040 Jefferson, McKeesport Pa.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **9**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **24**
year **1944** hour **10** minute **25** A.M.

21. I hereby certify that I attended the deceased from **May 17**, 1944, to **May 24**, 1944
that I last saw him alive on **May 24**, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumatic heart disease with mitral stenosis**
Duration **3 yrs.**

Due to _____
Due to **92**
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **B. H. ...** (M. D. or other) **MD**
Address **BARNES HOSPITAL** Date signed **5/24/44**

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

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed

S. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen a

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.