

FILED JAN 20 1945 318

Primary Registration District No. 100

Registrar's No. 293

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether
In this community 9 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1451 Cleary
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME James Davis

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

4. Sex Male Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lula Davis
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased May 2 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 8 4 hr. min.

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

10. Usual occupation Garbage Collector

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown ? 9
(City, town, or county) (State or foreign country)
14. Maiden name Poity
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Lula Davis
(b) Address 1451 Cleary

17. (a) Burial (b) Date thereof 1-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation GREENWOOD CEM.

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St

19. (a) J. F. Bundeck 1945
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6th
year 1945 hour 2 minute 27 P.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 Cerebral Hemorrhage

Due to 8321
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?

While at work (Specify type of place) (c) Means of injury

23. Signature W. H. ... M. D. or other) Address ... Date signed 1/9/48

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

Signed..... *Fulton G. Culkin*

Licensed Embalmer No. *4198-*

P. O. Address *1215 Jones St. Louis 13*

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.