. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15043

FILED JUN 4 1945

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 4629

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: Homer Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17 25

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

(d) Street No. 1454 O'Fallon 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sarah Davis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 5. Color or race Col 6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife ISH DAVIS

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased UNK (Month) — (Day) — (Year)

8. AGE: Years 53 Months — Days — If less than one day hr. min.

ABT

9. Birthplace ST LOUIS (City, town, or county) MO 0 (State or foreign country)

10. Usual occupation DOMESTIC

11. Industry or business

FATHER
12. Name UNK
13. Birthplace (City, town, or county) KY 1 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace UNK (City, town, or county) MO 0 (State or foreign country)

16. (a) Informant ISH DAVIS
(b) Address 1454 O'FALLON

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 26 45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director JAMES H. HARRISON
(b) Address 2906 LAWTON

19. (a) MAY 25 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21, year 1945 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from May 15, 1945 to May 21, 1945; that I last saw her alive on May 21, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebro-vascular accident	Unk.
Due to	
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature B. F. Murphy (M. D. or other)

Address Geo. Whittier Date signed 5/22/45

(Licensed Embalmer's Statement on Reverse Side)

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard St

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.