

FILED JUL 3 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21190

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1640

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mt. St. Rose Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5120 Northland Ave.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM F. DAVIS

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

4. Sex Male 5. Color or race White 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 40 years  
7. Birth date of deceased July 29 1897  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>10</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation St. Car Operator

11. Industry or business \_\_\_\_\_

12. Name William F. Davis  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Blanche Boulward  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Nellie Davis  
(b) Address 5120 Northland Ave.

17. (a) Burial (b) Date thereof 8-30-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd

19. (a) 6-28-45 (b) E. H. Mc Gowan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27  
year 1945 hour 2 minute 46 M.

21. I hereby certify that I attended the deceased from Jan 21 1945 to June 27 1945  
that I last saw him alive on June 27 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Far-Aden Pul. Tbc Duration 1 1/2 yrs.

Due to 136'  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations None  
Of autopsy None

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 injury) (e) Means of injury 0

23. Signature John C. Murphy (M. D. or other) M.D.  
Address 901 So Broadway Date signed 6-27-45

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

MOTHER FATHER

AUG 30 1945

JUL 5 1945

**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 Warren A. Carver

Licensed Embalmer No. 3534

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.**