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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31804

FILED NOV 1 1945

Registration District No. 3185

Primary Registration District No. 1003

Registrar's No. 9441

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

1. PLACE OF DEATH:

(a) County: St. Louis

(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: (Specify whether years, months or days)

In this community: 102 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 000

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

(d) Street No.: 4615 Lindell Blvd.
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: JAMES O. DAVIES

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: Fay K. Davies

6. (c) Age of husband or wife if alive: 58 years

7. Birth date of deceased: July (Month) 13 (Day) 1882 (Year)

8. AGE: Years 63 Months 3 Days 18 If less than one day hr. min.

9. Birthplace: Vienna (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Manager

11. Industry or business: Baby Touch Hair Remover Co.

FATHER
12. Name: Newton Davies
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Luella Chapman
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Fay K. Davies
(b) Address: 4615 Lindell Blvd.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Nov. 1, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Cairo, Illinois

18. (a) Signature of funeral director: C. Hoffmeister U.&D. Co.
(b) Address: 7814 S. Broadway

19. (a) NOV 1 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 31 year 1945 hour 12:50 minute Noon M.

21. I hereby certify that I attended the deceased from 7-21, 1945 to 10-31, 1945 that I last saw him alive on Oct. 31, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: RESPIRATORY ARREST	
Due to: COMPRESSION OF TRACHEA	
Due to: CARCINOMA OF ESOPHAGUS	
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: H. Bradley (M. D. or other)
Address: Barnes Hospital Date signed: Nov 1 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. Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.