

No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2391
Registrar's No. 377

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(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 4 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Kitty Davis
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race Col
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 27 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 1 13 hr. min.

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

10. Usual occupation Housework

11. Industry or business _____

12. Name Bill Staten

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

14. Maiden name Dealer Foot.
(City, town, or county) (State or foreign country)

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

16. (a) Informant Louise Young

(b) Address 2835 Howard St

17. (a) Burial (b) Date thereof 1/14/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director Price + Walker

(b) Address 2829 Washington Blvd.

19. (a) JAN 13 1947 (b) J. P. Bredeck
(Date received local registrar) (Registrar's signature)

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. 2835 Howard
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 10
year 1947 hour 11 minute 50 A M.
21. I hereby certify that I attended the deceased from 1-6 1947, to 1-10 1947
that I last saw her alive on Jan. 10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Lungs) Duration Undet.

Due to _____
Due to _____

Other conditions Heart - Hypertrophy
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Yes
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 Edw. B. Williams (M. D. or other) _____

Address 2601 N Whittier Date signed 1/11/47

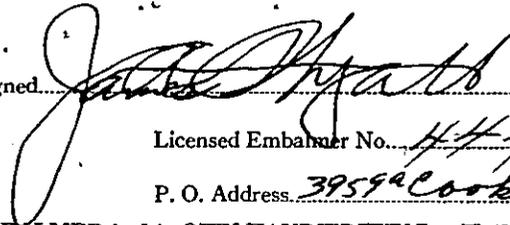
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 4441

P. O. Address. 39592 Cook Ave

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Ketty Davis

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife husband now 6. (c) Age of husband or wife if alive 27
7. Birth date of deceased 27 (Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

MOTHER FATHER

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bineck (Registrar's Signature) _____
(Data received local registrar)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1945 (hour) _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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.

Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

2391

NE-0348