

No. 2  
1/47  
5-17-39

FEDERAL BUREAU OF INVESTIGATION

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **18737**  
Registrar's No. **5325**

National Office of Vital Statistics

FILED JUN 13 1947

Registration District No. **318**

Primary Registration District No. **1003**

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

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:  
**Firmin Delosgee Hosp'n**  
(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..... **000**

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

(d) Street No..... **5560 Pershing Ave**  
**12** (If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME..... **LEWIS K. DAVIS**

3. (b) If veteran, name war.....

3. (c) Social Security No. **261-26-1379**

4. Sex..... **male**

5. Color or race..... **W.**

6. (a) Single, widowed, married, divorced..... **unk'd**

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

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

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

8. AGE:	Years	Months	Days	If less than one day
	<b>abt 50 yr</b>	-	-	.....hr.....min

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

10. Usual occupation..... **Salesman**

11. Industry or business..... **Tobacco**

12. Name..... **Unknown**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **Firmin Delosgee Hosp Room**

(b) Address.....

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof..... **5/29/1947**  
(Month) (Day) (Year)

(c) Place: burial or cremation..... **Mt. Olive**

18. (a) Signature of funeral director..... **Wayer**

(b) Address..... **4356 Lindall Blvd**

19. (a) **MAY 29 1947** (Date received local registrar's) (b) **J. J. Bredeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **May** day..... **23**  
year..... **1947** hour..... **1** minute..... **40 p.m.**

21. I hereby certify that I attended the deceased from..... **5-8**, 19**47** to..... **5-23**, 19**47**  
that I last saw him alive on..... **5-23**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Staphylococcus Septicemia**

Due to..... **Infected finger right index**

Due to..... **no**

Other conditions..... **no**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations..... **JH**

Of autopsy..... **no**

Duration.....

PHYSICIAN.....

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Nature of 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..... **(1)**

23. Signature..... **Victor E. Scherman** (M. D. or other)

Address..... **508 W. Grand** Date signed..... **5-29-47**

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**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.....

*John S. Penneke*

Licensed Embalmer No. 4194

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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.....  
years, months or days)

3. (a) PRINT FULL NAME Lewis X. Davis

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

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

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

8. AGE: Years Months Days  
at 50 If less than one day  
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER  
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) (Date received local registrar) (b) J. F. Bredek  
(Registrar's signature)

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 June Day 23  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
to.....  
that I last saw him..... alive on.....  
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.....

SUPPLEMENTARY

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

AUG 25 1947

S-18737

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