. S. No. 2
DM—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 18 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32432

Registration District No. 818 | Primary Registration District No. 1003 | Registrar's No. 8600

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: ST. LOUIS MATERNITY HOSPITAL 0
(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 MISSOURI (b) County

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4112 A PAGE AVE. 9
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME INFANT FEMALE DAVIS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE 2

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased SEPTEMBER (Month) 6 (Day) 47 (Year)

8. AGE: Years | Months | Days 4 | If less than one day 1 hr. 50 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name TIMOTHY DAVIS (DECEASED)
13. Birthplace ROLAND, (City, town, or county) ARKANSAS (State or foreign country)

MOTHER
14. Maiden name SAMUELLA PERRY
15. Birthplace LITTLE ROCK (City, town, or county) ARKANSAS (State or foreign country)

16. (a) Informant ST. LOUIS MATERNITY HOSPITAL
(b) Address 630 S. KINGSHIWAY

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 9-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cemetery Illinois

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney

19. (a) SEP 11 1947 (Date received local registrar) (b) J. F. Broleck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 10 year 1947 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from SEPTEMBER 6th 1947 to SEPTEMBER 10th 1947 that I last saw him alive on SEPTEMBER 10 1947 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Peripheral collapse and cardiac failure

Due to Gastric perforation and peritonitis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Perforation of stomach. Fibrinous peritonitis

PHYSICIAN

Underline the cause of 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 Herbert Mayer (M. D. or XXX)

Address 630 So. Kingshighway Date signed 9-11-47

Jefferson City Printing Co.

(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.....

Licensed Embalmer No.....

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.