

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

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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 28 1948
Registration District No. **318**

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

27630
State File No. _____
Registrar's No. **7224**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town _____
(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 20 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Josephine L. Davis
3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex F. 1 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CHARLES P. DAVIS 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased APR. 21 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 3 25 hr. _____ min. _____

9. Birthplace E. St. Louis ILL. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Geo. J. HEINE
13. Birthplace CHESTER ILL. 1
(City, town, or county) (State or foreign country)
14. Maiden name LUTA LANCASTER
15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant CHARLES P. DAVIS
(b) Address 4515 MARGARETTA AVE
17. (a) BURIAL (b) Date thereof 8/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Stuart & Canale
(b) Address 4600 N. 1st ST. BRIDGE
19. (a) AUG 17 1948 (b) J. T. Burdick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4515 MARGARETTA AVE 9
10 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16
year 1948 hour 5 minute 50 P.M.
21. I hereby certify that I attended the deceased from July 27,
1948 to August 16 1948
that I last saw h. er alive on August 16 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema, postoperative

Due to Right lower lobectomy

Due to 106
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Bronchiectasis, right
Of operations lower lobe
Of autopsy Pulmonary edema and hemorrhage.

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 FR Bradley (M. D. or other) 0
Address Barnes Hospital Date signed 8/27/48

over

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 *J. Allen Davis*

Licensed Embalmer No. *# 4053*

P. O. Address *St. Louis Mo*

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.