

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

FEDERAL BUREAU OF INVESTIGATION  
 NATIONAL OFFICE OF VITAL STATISTICS  
 U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
 MISSOURI DIVISION OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

34045  
 9280

FILED NOV 12 1948

State File No. \_\_\_\_\_  
 Registrar's No. \_\_\_\_\_

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  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 28 YEARS  
 years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MO (b) County 000  
 (c) City or town ST. LOUIS 12  
 (If outside city or town limits, write "RURAL") 9  
 (d) Street No. 3302 LAELEDGE 1  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** JORDON DAVIS  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. **DATE OF DEATH:** Month Oct day 25  
 year 1948 hour 7:41 minute A. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race COL  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death Fatty Degeneration of the Heart  
 Due to \_\_\_\_\_  
 Due to 93d  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

7. Birth date of deceased: MAR 29 1870  
 (Month) (Day) (Year)  
 8. **AGE:** Years 78 Months 7 Days 26 hr. \_\_\_\_\_ min. \_\_\_\_\_  
 If less than one day

9. Birthplace TENN  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation LABOR  
 11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name UNKNOWN  
 13. Birthplace TENN  
 (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 CORA AUSTIN  
 (b) Address 2302 LAELEDGE  
 17. (a) BURIAL (b) Date thereof NOV 6 1948  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation FATHER DIERSON  
 18. (a) Signature of funeral director F. A. GREEN  
 (b) Address 4214 DELMAR, Blvd  
 19. (a) OCT 27 1948 (b) J. B. Pascoe  
 (Date received local registrar) (Registrar's signature)

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 3  
 23. Signature Wm. Perry (M. D. or other) \_\_\_\_\_  
 Address 1012 1/2 W. 1st St. Date signed 10/26/48

**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..... *F. G. Green* .....

Licensed Embalmer No. *2963* .....

P. O. Address. *4217 Delmar* .....

**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.**