

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38019**
Registrar's No. **10388**

Registration District No. **318**

Primary Registration District No. **1003**

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:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 6842 Arthur Ave.
3 (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Owen Davis

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anita Adele 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased September 18, 1891
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 9 If less than one day
hr. _____ min. _____

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

10. Usual occupation Supt. of Term. Frisco R.R.

11. Industry or business _____

12. Name Emil Davis
13. Birthplace Springfield, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Irene Burford
15. Birthplace Marshfield, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Anita Adele Davis

(b) Address 6842 Arthur Ave.

17. (a) Burial (b) Date thereof 11-30-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Rd.

19. (a) NOV 30 1948 (b) J. B. Lesater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1948 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-20-48
_____, 19____, to 11-27, 1948

that I last saw him alive on 11-27, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____
Of autopsy Lobar Pneumonia
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 1

23. Signature P. B. Cappella (M. D. or other) MD

Address 3284 Frontline Date signed 11-28-48

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

MOTHER FATHER

He 2502
SV 84, 100000
2000 01

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..... *H. P. Burgess*
.....
Licensed Embalmer No. *4029*
P. O. Address: *Maplewood*

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.