

FILED MAY 11 1949  
#42314

STANDARD CERTIFICATE OF DEATH.

State File No. 13699  
3788  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 700 a South 4th	
3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) DAVIS c. (Last) DAVIS			4. DATE OF DEATH (Month) (Day) (Year) April 27, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct-13-1883
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	11. BIRTHPLACE (State or foreign country) ILLINOIS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY own	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME ALBERT LANE		13b. MOTHER'S MAIDEN NAME JENNIE CHAMBERS	14. NAME OF HUSBAND OR WIFE JOHN DAVIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS E. J. SCHNUR 3125 LAFAYETTE

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Disease		ANTECEDENT CAUSES		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____		
		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. Hiatus Hernia,		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 93d
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/13/49, 19, to 4/27/49, 19, that I last saw the deceased alive on 4/27/49, 19, and that death occurred at 5:50am, from the causes and on the date stated above.

23. SIGNATURE (Degree or title) 23b. ADDRESS 23c. DATE SIGNED  
J. B. Lanter, M.D. 1515 Lafayette Ave., 4/27/49

24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 24b. DATE APRIL 30 1949 24c. NAME OF CEMETERY OR CREMATORY Mo. Crematory 24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL OFFICE APR 28 1949 REGISTRAR'S SIGNATURE J. B. Lanter 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS EJ SCHNUR 3125 Lafayette

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

*Handwritten mark*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Handwritten signature: Joe B. Volmer*

Licensed Embalmer No. 4014

P. O. Address 3125 Fayette St -

**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.