

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20933**
Registrar's No. **5970**

FILED JUL 15 1949

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 5970	
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY 000		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital			d. STREET ADDRESS (If rural, give location) 21 3128a Sheridan Ave		
3. NAME OF DECEASED a. (First) Elizabeth (Type or Print)			b. (Middle) Davis		c. (Last)
4. DATE OF DEATH July 4th 1949			4. DATE (Month) (Day) (Year)		
5. SEX female	6. COLOR OR RACE col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec 28th 1907	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Fort Smith Ark		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Jones		13b. MOTHER'S MAIDEN NAME Eliza Mitchell		14. NAME OF HUSBAND OR WIFE Henry 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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry Davis 3128a Sheridan Avenue	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MIelial (myocardial) Hypertension ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 920	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? HIX	
22. I hereby certify that I attended the deceased from July 1st, 1949 , to July 4th, 1949 , that I last saw the deceased alive on July 3rd, 1949 , and that death occurred at 8 PM m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) W. W. Wessone M.D.			23b. ADDRESS 4141 Page		23c. DATE SIGNED 7-5-49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7-8-1949	24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Missouri
DATE REC'D BY LOCAL REG. 1111 7 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave	

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

J. J. Stator

Signed.....

Student Embalmer.....

Licensed Embalmer No. *2698*

P. O. Address *2769 Shorten*

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.