

STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1008

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.
c. LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Illinois b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normal, Ill.
d. STREET ADDRESS Manning Trailer Court

3. NAME OF DECEASED
a. (First) Susan b. (Middle) Jane c. (Last) Davis

4. DATE OF DEATH (Month) (Day) (Year)
Aug. 25, 1950

5. SEX female
6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) U

8. DATE OF BIRTH Aug 21-1947

9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 3 IF UNDER 1 HR. Hours 0 Mtn. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Roy C. Davis

13b. MOTHER'S MAIDEN NAME Jane Wolfe

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Roy C. Davis, Normal, Ill.

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullablastoma
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.

INTERVAL BETWEEN ONSET AND DEATH
6 wks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 192X

22. I hereby certify that I attended the deceased from 8-18-1950 to 8-25, 1950, that I last saw the deceased alive on 8-25, 1950, and that death occurred at 7:25 pm., from the causes and on the date stated above.

23a. SIGNATURE Dr. L. Shuster M.D. U (Degree or title)

23b. ADDRESS Children's Hosp

23c. DATE SIGNED 8/29/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Aug. 25, 1950

24c. NAME OF CEMETERY OR CREMATORY Carlyle, Ill.

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. AUG 26 1950 REGISTRAR'S SIGNATURE J. B. Pasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister Colonial Mortuary 616 1/2 Chicago St.

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

1911

1924

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.....
Student Embalmer

Signed *Harry J. Schumacher*

Licensed Embalmer No. *2679*

P. O. Address *7814 1/2 Broadway*

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.