

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5995
1819

State File No. _____
Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2719 BERNARD		e. STREET ADDRESS (If rural, give location) 2719 BERNARD	
3. NAME OF DECEASED (Type or Print) SARAH DAVIS a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 2 21 51
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 4, 1870
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	11. BIRTHPLACE (State or foreign country) Huntsville Ala
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Stafford Pope	13b. MOTHER'S MAIDEN NAME Margaret Marshall
14. NAME OF HUSBAND OR WIFE John Davis deceased		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 John H. Windsor ADDRESS 2719 BERNARD			
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) Apoplexy ANTECEDENT CAUSES Senility 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 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)	
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? 334K	
22. I hereby certify that I attended the deceased from Feb 16, 1951 , to Feb 21, 1951 , that I last saw the deceased alive on _____, 19____, and that death occurred at 140 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. S. Lagunes M.D.		23b. ADDRESS 3025 S. Jefferson	23c. DATE SIGNED Feb 23-51
24a. BURIAL / CREMATION / REMOVAL (Specify) BURIAL	24b. DATE 2-24-51	24c. NAME OF CEMETERY OR CREMATORY ST PETERS	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 23 1951		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennie Love 3103 Washington	

WRITE PLAINLY—USING UNFADEING 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.....

W. Claude Gordon

Signed.....
Student Embalmer

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.