S. No. 300
V. 10.48

FILED FEB 16 1951

STANDARD CERTIFICATE OF DEATH

State File No. 5998

#72521

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 946

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis,Mo.
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St.Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis 2199
19. STREET ADDRESS (If rural, give location): 3715 Olive St.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle):
c. (Last): DAVIS

4. DATE OF DEATH (Month) (Day) (Year): Jan. 29th,1951

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Dec. 9 1896
9. AGE (In years last birthday): 54 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glazier
10b. KIND OF BUSINESS OR INDUSTRY: Glass
11. BIRTHPLACE (State or foreign country): St.Louis Mo. 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: John Davis
13b. MOTHER'S MAIDEN NAME: Anna Kopp
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 488-07-1629
17. INFORMANT'S SIGNATURE OR NAME: Anna Kopp — **ADDRESS**: 714 Tiffin Ferguson Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH

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 ☐ 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 38/1

22. *I hereby certify that I attended the deceased from* 1/19/51, *19*____, *to* 1/29/51, *19*____, *that I last saw the deceased alive on* 1/29/51, *19*____, *and that death occurred at* 3:45am., *from the causes and on the date stated above.*

23a. SIGNATURE John R. Beem (Degree or title) M.D.
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 1/29/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/31/51
24c. NAME OF CEMETERY OR CREMATORY: Memorial Park
24d. LOCATION (City, town, or county) (State): St.Louis County

DATE REC'D BY LOCAL REG.: JAN 30 1951
REGISTRAR'S SIGNATURE: J. B. Lancaster
25. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Sullivan Funeral Dir., 3640 N.Euclid

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 22 1951

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 Robert L. Brinkman

Signed.....
Student Embalmer

Licensed Embalmer No. 3523

P. O. Address St Louis M

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.