

FILED JAN 10 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42866
Registrar's No. 11360

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>2257</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St Louis</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St Louis</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>1129 E. N. 9th St</i>		d. STREET ADDRESS (If rural, give location) <i>23 1129A N - 9th</i>	

3. NAME OF DECEASED (Type or Print) JOHN			4. DATE OF DEATH (Month) (Day) (Year) <i>12 20 57</i>		
a. (First)	b. (Middle)	c. (Last)			
		DAVIS			

5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cal</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>7-4-1881</i>	9. AGE (In years last birthday) <i>70</i>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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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) <i>Maryanna Ark</i>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <i>Not known</i>	13b. MOTHER'S MAIDEN NAME <i>not known</i>	14. NAME OF HUSBAND OR WIFE
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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
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocardial Infarction & Sepsis</i>		
	ANTECEDENT CAUSES <i>Mitral Insufficiency</i>		
	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>410X</i>
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22. I hereby certify that I attended the deceased from *10-12, 1957*, to *12-19, 1957*, that I last saw the deceased alive on *12-19, 1957*, and that death occurred at *12-20m.* from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>J. W. Wilkinson MD</i>	23b. ADDRESS <i>4141 P...</i>	23c. DATE SIGNED <i>12-21-57</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>12-26-57</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	24d. LOCATION (City, town, or county) (State) <i>St Louis County Mo</i>
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DATE REC'D BY LOCAL REG. <i>DEC 22 1957</i>	REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. Richardson 2625 Glasgow</i>
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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 *A. D. Richardson*

Signed.....
Student Embalmer

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.