

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

7470

State File No. ....

1589

FILED FEB 26 1953

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jefferson</u>					
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St Louis Mo</u>		c. LENGTH OF STAY (in this place) <u>2 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Near Cedar Hill Mo</u>		0509			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo Baptist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Meramec Township</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>LENA</u> b. (Middle) <u>MARIE</u> c. (Last) <u>DAVIS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 8 - 1953</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Feb 25 - 1883</u>			
9. AGE (In years last birthday) <u>69</u>		10. F UNDER 1 YEAR Months <u>11</u>		10. F UNDER 1 YEAR Days <u>13</u>		10. F UNDER 1 YEAR Hours <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lowell Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Samuel</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Dolt</u>			14. NAME OF HUSBAND OR WIFE <u>William S. Davis (Dec)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Davis 7611st St OMO</u>					
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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>				DUE TO (b) <u>arteriosclerotic hypertension</u>				<u>16 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <u>Hypertensive heart disease</u>				<u>unknown</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								<u>unknown</u>	
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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>1-24</u> , 19 <u>53</u> , to <u>2-8</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2-8</u> , 19 <u>53</u> , and that death occurred at <u>2 P m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Wm. R. Gunn M.D.</u>				23b. ADDRESS <u>2227 S Broadway</u>			23c. DATE SIGNED <u>2-10-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Feb 11, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hillsboro Mo RR #2 Mo</u>			
DATE REC'D BY LOCAL REG. <u>FEB 10 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. EMBALMER'S SIGNATURE <u>Wm. R. Gunn</u>		ADDRESS <u>Local Springs Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....

*Barry J. Moran*

Signed.....  
Student Embalmer

Licensed Embalmer No. *11366*

P. O. Address *St Louis Mo*

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.