

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2381

No. 300
10.48

FILED MAR 24 1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2381	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) <u>15 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>LEMAI</u>		4860	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CHILDREN'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>3901 MT. OLIVE ROAD</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOAN</u>		b. (Middle) <u>DEE</u>		c. (Last) <u>DAVIS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 27, 1953</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>OCT. 21, 1950</u>		9. AGE (In years last birthday) <u>2 yrd</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>CALIFORNIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN RILEY DAVIS</u>			13b. MOTHER'S MAIDEN NAME <u>HILDA KIRSHKORN</u>			14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Barbara Sutton 500 S. Kings Highway</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fibrositic disease of Bronchus</u> 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	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5872</u>					
22. I hereby certify that I attended the deceased from <u>2-12</u> , 19 <u>53</u> , to <u>2-27</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>53</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. Klingberg MD</u> (Degree or title)				23b. ADDRESS <u>500 S. KINGSHIGHWAY</u>		23c. DATE SIGNED <u>2/27/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>3/3/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>LEMAI, MO.</u>	
DATE REC'D BY LOCAL REG. <u>MAR 3 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. FENDLER UND. CO., 7420 MICHIGAN</u>		

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

112 15 9. 24 1954

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Ben G. Johnson*

Licensed Embalmer No. *14366*

P. O. Address *W. B. G.*

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.