

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15604

State File No.

FILED APR 18 1953

3525

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>MISSOURI</u> b. COUNTY <u>2237</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>St. Louis City Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>23 1719th S. 9TH ST.</u>			
3. NAME OF DECEASED (Type or Print); a. (First) <u>JANET</u> b. (Middle) <u>-</u> c. (Last) <u>DAVIS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 2, 1953</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAR. 23 1889</u>		9. AGE (In years last birthday) <u>64</u>	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) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>		12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM SINGELTON</u>			13b. MOTHER'S MAIDEN NAME <u>ELLA HORMAN</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM DAVIS</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>WILLIAM DAVIS 1719th S. 9TH ST.</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, ashenia, 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>Myocardial Infarction</u>						
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Arteriosclerosis</u>						
	DUE TO (c) <u>Uremia due to Nephrosclerosis</u>						
	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 checked="" 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? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>3-8-53</u> , 19 <u> </u> , to <u>4-2-53</u> , 19 <u> </u> , that I last saw the deceased alive on <u>4-2-53</u> , 19 <u> </u> , and that death occurred at <u>12:00P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Death or title) <u>Ann Higgins, MD</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>4-3-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>APR. 6 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>		
DATE REC'D BY LOCAL REG. <u>APR 3 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Bravis</u>			

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Homer C Dill*.....

Licensed Embalmer No. *4347*.....

P. O. Address *2906 Bravoi*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.