

FILED JAN 5 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 44150

BIRTH NO. 92010 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11855

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		e. STREET ADDRESS (If rural, give location) 18 3705a Chouteau Avenue 2187			
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Davis November 30 1953			
5. SEX Female		6. COLOR OR RACE Negro		8. DATE OF BIRTH November 30 1953	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		9. AGE (In years last birthday) 17		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Norman Rayfield Davis	
13b. MOTHER'S MAIDEN NAME Lillian Cleo Stewart		14. NAME OF HUSBAND OR WIFE		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 Hospital Records			

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) Intracranial Hemorrhage  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Precipitous Labor DUE TO (c) Contracted Pelvis  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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7600	

22. I hereby certify that I attended the deceased from Nov 30, 19 53 to Nov 30, 19 53, that I last saw the deceased alive on Nov 30, 1953, and that death occurred at 2:57 P., from the causes and on the date stated above.

23a. SIGNATURE E. H. Hance M.D. (Degree or title)		23b. ADDRESS 630 S. Kingshighway		23c. DATE SIGNED 9 Dec, 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-31-53		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) St. Louis, Mo.		24e. (State)			

DATE REC'D BY LOCAL REG. DEC 16 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D. (Licensed Embalmer's Statement on Reverse Side)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rawland 4104 Manchester	
--------------------------------------	--	--	--	--	--

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.....

Licensed Embalmer No.....

P. O. Address .....

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.