

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

20373

4633

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 Missouri				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 0		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 18 2928 Market					
3. NAME OF DECEASED (Type or Print) a. (First) Willie			b. (Middle) Belle		c. (Last) Davis		4. DATE OF DEATH (Month) (Day) (Year) May 20, 1954		
5. SEX Female 3		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 17, 1910		9. AGE (In years last birthday) 44 If UNDER 1 YEAR: Months 8 Days 3 If UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Dublin, Georgia /			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Arthur Daniel			13b. MOTHER'S MAIDEN NAME Mattie Coats			14. NAME OF HUSBAND OR WIFE Jessie Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Melena Hicks				ADDRESS 4216 W. Finney	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pelvic Abscess, Ostronthritic Osteomyelitis, of Pelvis						INTERVAL BETWEEN ONSET AND DEATH Undt	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary Hydronephrosis							
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) 626 X					
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? _____					
22. I hereby certify that I attended the deceased from Mar. 9, 1954 , to May 20, 1954 , that I last saw the deceased alive on May 20, 1954 , and that death occurred at 10:00p m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Carl Belle Smith M. D.				23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 5/22/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/27/54		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. MAY 24 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Smith 4019 Washington				

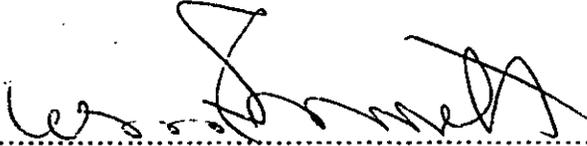
WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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. 43

P. O. Address St. Louis

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.