

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026880
STATE FILE NUMBER

FILED JUL 18 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6634

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Richmond Heights 17
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b 3 Days	d. STREET ADDRESS (If outside, give location) 1137 Terrace Dr.
3. NAME OF DECEASED (Type or print) First Middle Last JUDSON (NMN) DAVIS			4. DATE OF DEATH Month Day Year JULY 1, 1958
5. SEX M. C	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Div. Sales Represent		10b. KIND OF BUSINESS OR INDUSTRY Wolch Nut & Candy	11. BIRTHPLACE (City and state or country) Imboden, Arkansas
13a. FATHER'S NAME Judson (NMN) Davis		13b. MOTHER'S MAIDEN NAME Mary Borah	14. NAME OF HUSBAND OR WIFE Florence Carson Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-03-1198	17. INFORMANT Address Florence C. Davis 1137 Terrace Dr 17
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO (b) ACUTE MONOCYTTIC LEUKEMIA DUE TO (c) 204.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH FEW HOURS 5 MONTHS
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from JUNE 29, 1958 to JULY 1, 1958 and last saw her alive on JULY 1, 1958 Death occurred at 9:35 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) FR Bradley M. D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 7/2/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 3, 1958	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Bl.		25. DATE RECD. BY LOCAL REG. JUL 2 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *jos. E. McCullor*

Licensed Embalmer No. *2460*

P. O. Address *6175 Pellm*

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.