Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-003200

3 10 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 305

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN CLAYTON (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) County Hosp. Length of stay in 1b 15 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY ST LOUIS
c. CITY OR TOWN Webster Groves Mo 4597 Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 10. W. Newport Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First ANNA Middle Last DAVIS
4. DATE OF DEATH Month 1 Day 29 Year 59
5. SEX F 3
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-17-74
9. AGE (In years last birthday) 84 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) housekeeper
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Jackson, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Lewis Davis
13b. MOTHER'S MAIDEN NAME Armanta Hawkins
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 Address Ora Mae James, Webster Groves, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal Ulcer, old.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from —, to — and last saw her alive on 1/14/59
Death occurred at — P. m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Angelo A. Speno M.D. (Degree or title)
22b. ADDRESS 601 S. Brentwood Bl.
22c. DATE SIGNED 1/29/59.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE Feb. 2, 1959
23c. NAME OF CEMETERY OR CREMATORY Father Dickson
23d. LOCATION (City, town, or county) (State) Kirkwood. Mo.
24. FUNERAL DIRECTOR A.L. Beal Und. Co. ADDRESS 4303 Delmar
25. DATE RECD. BY LOCAL REG. 1-31-59
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
(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 A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 N. Glas

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.