

Dept. Health,  
c., & Welfare  
S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-041730

STATE FILE NUMBER

21020

FILED VS NOV 3 0 1959

Registration District No. Primary Registration District No. Registrar's No.

V. S. 300  
Rev. 1-57  
28  
1953

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS <b>3723 Olive St.</b>	

3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Earle</b> Last <b>Davis</b>			4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>59</b>			
---	--	--	---	--	--	--

5. SEX <b>3</b> <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>ab. 74</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
----------------------------------	----------------------------------	---	------------------------------------	--	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Raymond Miss.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	--	--	---

13a. FATHER'S NAME <b>David McRae</b>	13b. MOTHER'S MAIDEN NAME <b>Mariah Thomas</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>David McRea</b>	Address <b>4360 Wash. Blvd.</b>
---	---	-------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decaying lung branches pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>491X</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)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 a.m. p.m.	Month, Day, Year
---	------------------

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>James M. Dickson</i> (Deceased's Sign)	22b. ADDRESS <b>1300 Oak</b>	22c. DATE SIGNED <b>11/6/59</b>
---	---------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/9/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <b>Grant Johnson</b>	ADDRESS <b>4352 Wash. Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 6 1959</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
--	------------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *F. A. Green* .....

Licensed Embalmer No. *2963* .....

P. O. Address *4214 Palmer* .....

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.