

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020822

FILED VS MAY 18 1960

318

Primary Registration District No.

1003

Registrar's No.

4985

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>OUR LADY OF PERPETUAL HELP NURSING HOME</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6652 McCUNE AVENUE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA T. DAVIS</b>			4. DATE OF DEATH Month Day Year <b>MAY 10, 1960</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</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>8/19/1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>FRANK GRAF</b>			13b. MOTHER'S MAIDEN NAME <b>1st UNKNOWN HICKEL</b>			14. NAME OF HUSBAND OR WIFE <b>WILLIAM J. DAVIS</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.		17. INFORMANT Address <b>WILLIAM J. DAVIS, 5924 HOLYOKE DRIVE AFFTON, MO.</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>Cerebral vascular accident</b> <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Senility</b>						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 WORK <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 <b>October 7, 1959</b> to <b>death</b> and last saw her alive on <b>May 5, 1960</b> Death occurred at <b>10:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Joseph C. (Ingram, M.D.)</b> (Degree or title)			22b. ADDRESS <b>3284 Ivanhoe St. Louis Mo</b>			22c. DATE SIGNED <b>5.11.60.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>5/13/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>W. FLORISSANT AVE. ST. LOUIS, MO</b>				
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY</b> <b>6464 CHIPPEWA STREET, ST. LOUIS, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 11 1960</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

201 1/2

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill C. Dransow

Licensed Embalmer No. 476

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.