

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, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS (If outside, give location) 4800a North Broadway	

3. NAME OF DECEASED (Type or print) First Milton Middle Edward Last Davis			4. DATE OF DEATH Month Sept. Day 17 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1927	9. AGE (last birthday) 32	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Carter Carb. Co.		11. BIRTHPLACE (City and state or country) Roanoke Rapids, N.C.	
13a. FATHER'S NAME Johmie C. Davis			13b. MOTHER'S MAIDEN NAME Lula Bell Jackson		14. NAME OF HUSBAND OR WIFE Nil.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. # 2		16. SOCIAL SECURITY NO. 216-30-9499		17. INFORMANT Roger Davis, 4118a North Grand, Ave.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fractured Neck Subdural Hemorrhage DUE TO (c) 9040 21			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Supporter in bed depressed fell and			

19. WAS AUTOPSY PERFORMED? YES <input 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) Struck head against wall in room of home	PART III. If deceased was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	Exact time and date could not be determined		

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.) Home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY STATE
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 505 P. _____ on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Patricia Taylor Carmel		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 9-20-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-20-60	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Roanoke Rapids, North Carolina	

24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. SEP 20 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

J. W. Burk

Licensed Embalmer No. 365

P. O. Address A. K. S.

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