ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-022456
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5376

FILED JUN 16 1961

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 — Length of stay in 1b: 22 yrs

c. CITY OR TOWN St. Louis — Inside Limits: Yes ☑ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips — Inside Limits: Yes ☑ No ☐

d. STREET ADDRESS (If outside, give location) 5094 Cabanne — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Jennie — Middle — Last Davis

4. DATE OF DEATH: Month 6 Day 6 Year 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-19-1891

9. AGE (last birthday): 70

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HR: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Star City Ark

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: Oliver Dunlap

13b. MOTHER'S MAIDEN NAME: Unkown

14. NAME OF HUSBAND OR WIFE: Alfonso Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Loraine Walton — Address: 5094 Cabanne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sarcoma of The Uterus — INTERVAL BETWEEN ONSET AND DEATH: Undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 174x

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. ☐ Yes ☑ No ☐ Unknown

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 3-27-61 to 6-6-61 and last saw her alive on 6-6-61

Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. H. Ward M.D.

22b. ADDRESS 2601 N. Whittier St.

22c. DATE SIGNED 6-7-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE 6-13-61

23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery

23d. LOCATION (City, town, or county) Berkley (State) Mo 40

24. FUNERAL DIRECTOR Price Und Co. Inc. ADDRESS 2829 Washington

25. DATE RECD. BY LOCAL REG. JUN 9 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

X 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 Edward O Flynn

Licensed Embalmer No. 4444

P. O. Address St Louis

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.