

318

1003

-61-042315

STATE FILE NUMBER

Registration District No.

Primary Registration District

Registrar's No.

10979

AMENDED

FILED DEC 1 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, MO

Length of stay in 1b

c. CITY OR TOWN St. Louis  
Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.

Inside Limits Yes  No

d. STREET ADDRESS (If outside, give location)  
2809 Goodfellow Blvd.  
Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print)  
First MIDDLE LAST  
LUCILLE DAVIS

4. DATE OF DEATH  
Month Day Year  
NOV. 23, 1961

5. SEX  
Female

6. COLOR OR RACE  
Negro

7. Married  Never Married   
Widowed  Divorced

8. DATE OF BIRTH  
7-14-1919

9. AGE (last birthday)  
42

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)  
Unk.

12. CITIZEN OF WHAT COUNTRY  
USA

13a. FATHER'S NAME  
Alex Davis

13b. MOTHER'S MAIDEN NAME  
unknown

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)  
no

17. INFORMANT Address  
Mr. Calvin Davis 3915 Cora

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

IMMEDIATE CAUSE (a)

Pulmonary Embolism (suspected)

DUE TO (b)

Atrial Fibrillation

DUE TO (c)

Arteriosclerotic Heart Disease

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

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)

420.0

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 s.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 11/16/61 to 11/23/61 and last saw her alive on 11/23/61  
Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE  
John M. Frough M.D.

22b. ADDRESS  
1515 LAFAYETTE AVE

22c. DATE SIGNED  
11/24/61

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

23b. DATE  
11-28-61

23c. NAME OF CEMETERY OR CREMATORY  
Washington Park Cemetery

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

24. FUNERAL DIRECTOR ADDRESS  
Atkins Bros. 3644 Finney Ave.

25. DATE RECD. BY LOCAL REG.  
NOV 25 1961

26. REGISTRAR'S SIGNATURE  
Loan Smith M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 John Cunningham  
Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.