

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

30756
Do not use this space.

1. PLACE OF DEATH **DEC'D OCT 12 1938**
 (a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis, Missouri** (d) Street No. **City Sanitarium** St.
 (e) Length of residence in city or town where death occurred **37** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Daisy Davidson Mitchell** **324**
 (a) Residence, No. **3430 a Grace Ave.** St. **76**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Widow of Frank**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **9-2-1880**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 **14**

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife**
 10. Date deceased last worked at this occupation (month and year) **1938**
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Ohio**

FATHER
 13. NAME **Jacob Davidson**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Ohio**

MOTHER
 15. MAIDEN NAME **Lena Wise**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Ohio**

17. INFORMANT (ADDRESS) **A.K. Busch, M.D. 5400 Arsenal St**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Motor to Boonville, Mo.** DATE **9/19/38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **A. W. McLaughlin 2301 Lafayette Avenue**

20. FILED **SEP 17 1938** *J. P. Busch* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-15-38**, 19
 22. I HEREBY CERTIFY, That I attended deceased from **8-29-38**, 19, to **9-15-38**, 19.
 I last saw her alive on **9-15-38**, 19. Death is said to have occurred on the date stated above, at **1:00 P.M.**
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage, left
9-15-38
 Date of onset

Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **A. K. Busch**, M. D.
 (Signed) **City Sanitarium**
 (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, _____

L. H. Cooper

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

L. H. Cooper

Licensed Embalmer No. _____

3633

P. O. Address _____

2317 Lafayette

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 this body is not embalmed, above space should be left blank.