

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.

Registration District No. 1000 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St Louis  
(c) Name of hospital or institution: Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 days  
Unknown (Specify whether  
In this community \_\_\_\_\_  
years, months or days) 25 years

8. (a) PRINT FULL NAME Watt Davis 120  
8. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex M 5. Color or race Col 6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife Anna V Davis 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
About 69 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) St. Louis, Ark (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna V. Davis  
(b) Address 1011 N. Cardinal Ave.

17. (a) \_\_\_\_\_ (b) Date thereof Jan 2 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director J W Hughes  
(b) Address 2620 Lawton

19. (a) DEC 21 1939 (b) \_\_\_\_\_  
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 25  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1609 Chestnut  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27  
year 1939 hour 9:00 minute 45 A.M.

21. I hereby certify that I attended the deceased from December 5, 1939, to December 27, 1939,  
that I last saw h. im alive on December 27, 1939,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Chronic Nephritis  
Luetic Heart Disease 23 days

Due to Prostatic Hypertrophy

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

28. Signature H. C. Irving (M. D. or other) \_\_\_\_\_  
Address 2601 N. Pittley Date signed \_\_\_\_\_

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Lyda Hughes*

Licensed Embalmer No. *2938*

P. O. Address *2620 Lawton*

**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.**