

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.

1. PLACE OF DEATH: 2
 (a) County _____
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5081 Wells Ave.,
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Margaret A. Davis 130
 3. (b) If veteran, name war _____ 3. (c) Social Security No. N11

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 24, 1867
 (Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Home work

11. Industry or business _____

MOTHER FATHER { 12. Name Martin Davis
 13. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Mary Lennon
 15. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia Davis
 (b) Address 5081 Wells Ave.,

17. (a) Burial (b) Date thereof 1/3/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.,

19. (a) DEC 31 1939 (b) _____
 (Registered local registrar) (District registrar)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5081 Wells Ave.,
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 31
 year 1939 hour 6.30 minute _____ P. M.

21. I hereby certify that I attended the deceased from December 26, 1939, to December 31, 1939;
 that I last saw her alive on December 31, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Broncho-pneumonia 6 days
Chronic myelomatosis 9 months

Due to _____

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 _____

23. Signature Frederick J. Killalee M.D. (M. D. or other)
 Address 8447, Chaffin Ave Date signed 1/1/40

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.....

J. G. Sullivan

Licensed Embalmer No. *1122*

P. O. Address.....

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.