

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8839**
Registrar's No. **2322**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
(b) City or town. **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution **3 days.** (Specify whether
In this community **60 Years**
years, months or days)

3. (a) PRINT FULL NAME **Lynn C. Davis**

3. (b) If veteran, name war. **None** 3. (c) Social Security No. **491-12-9439**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary Blong Davis** 6. (c) Age of husband or wife if alive. **UNK.** years

7. Birth date of deceased **May 2 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	10	6	hr. min.

9. Birthplace **Illinois.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Newspaper Writer.**

11. Industry or business **1**

MOTHER FATHER { 12. Name **James W. Davis.**

13. Birthplace **Illinois.**
(City, town, or county) (State or foreign country)

14. Maiden name **Ellen Buckmaster.**
Illinois.

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Davis**

(b) Address **5104 Vernon Ave**

17. (a) **Burial.** (b) Date thereof **Mar. 11, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd**

19. (a) **MAR 9 1940** (b) **J. B. Baker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. **Mo.** (b) County.....
(c) City or town. **St. Louis.** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. **5104 Vernon Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **8**
year **1940** hour **8** minute **15A** M.

21. I hereby certify that I attended the deceased from **2-27-1940** to **3-8-40**, 19**40**;
that I last saw him **alive** on **3-8-40**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **Myocarditis clis**

Due to **Arteriosclerosis General**

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **None**

Of autopsy **None**

Duration
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 **R. K. Anderson** (M. D. or other)

Address **4932 Maywood** Date signed **3/8/40**

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 William Matre
Licensed Embalmer No. 2825
P. O. Address 4340 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.