

791

Registration District No. _____

Primary Registration District No. _____

FILED DEC 11 1940

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)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____

(c) City or town **St. Louis, Mo 5**
(If outside city or town limits, write "RURAL")

(d) Street No. **5525 Ewing**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Dora Davis**

3. (b) If veteran, name war **No.**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ewing J.** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Nov. 10 1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
60	11	26	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Ohio**
(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 **Mrs. Lucille Kling**

(b) Address **4537a Bircher Place**

17. (a) **Burial** (b) Date thereof **11/9/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lake Charles Cem.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **NOV 9 1940** (b) _____
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **6** year **1940** hour **1** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **Oct 31, 1940** to **Nov 6, 1940**; that I last saw her alive on **Nov 6, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death: **Edema, lungs**

Duration **1 day**

Due to **acute bronchitis** **10 days**

Other conditions **Diabetes mellitus** **5 yr**
(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? _____

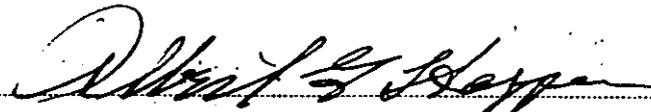
While at work? _____
(Specify type of place) (e) Means of injury

23. Signature **[Signature]** (M. D. or other) _____
Address **4500 Olive** Date signed **11/8/40**

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.....



Licensed Embalmer No. 2971

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, fact should be so stated above.