

FILED APR 20 1944 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **3292**

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:
807 South Eighteenth
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Twenty years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 307 South Eighteenth Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Davis

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or Race Col 6. (a) Single, widowed, married, divorced Widow
7. Birth date of deceased: April 15 1868
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Christinton Ky
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Mat Korman
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Chancy Murfery
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Chancy Drake

(b) Address 708 N 18th

17. (a) Burial (b) Date thereof 4-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washburn Park

18. (a) Signature of funeral director J. F. Bradeau

(b) Address _____

19. (a) APR 18 1944 (b) J. F. Bradeau
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1944 hour 4:30 p.m. minute _____ M.

21. I hereby certify that I attended the deceased from Dec. 23, 1943
to April 3, 1944
that I last saw her alive on April 3, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death: Bronchopneumonia

Duration 4 days

Due to _____

Due to _____

Other conditions: Senility
(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 C. R. Querry (M. D. or other)
Address 901a No Vandeventer Date signed 4-4-44

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

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 *W.P. Richards*
Licensed Embalmer No. *2928*
P. O. Address *2625 Glasgow*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Man*Registration District No. *318*Primary Registration District No. *1003*Registrar's No. *3292*

1. PLACE OF DEATH:

- (a) County *St. Louis*
 (b) City or town *St. Louis*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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 *Frank Owens*

3. (b) If veteran,
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex
- F*
5. Color or race
- B*
6. (a) Single, widowed, married,
-
- divorced
- W*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
-
- alive _____ years

7. Birth date of deceased
- Oct 15*
-
- (Month) (Day) (Year)

8. AGE: Years
- 75*
- Months
- 5*
- Days _____ (Unless than one day)
-
- min. _____

9. Birthplace _____
-
- (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

- MOTHER } 12. Name _____
 FATHER } 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a)
- MAY 2 1944*
- (b)
- J. F. Budeck*
-
- (Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
-
- year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
-
- that I last saw him _____ alive on _____, 19____;
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death _____

Duration _____

- Due to _____

- Due to _____

- Other conditions _____
-
- (Include pregnancy within 3 months of death)

- Major findings:
-
- Of operations _____

- Of autopsy _____

PHYSICIAN

Underline
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 (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 _____ (M. D. or other) _____

- Address _____ Date signed _____

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

SUPPLEMENTARY

12697