

7. S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED OCT 20 1944
 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
 1003

State File No. **32198**
 Registrar's No. **8601**

Registration District No. _____ Primary Registration District No. _____

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:
Missouri Baptist Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days**
(Specify whether)
 In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Illinois** (b) County **Union** 999
 (c) City or town **Anna** !!
(If outside city or town limits, write "RURAL") NB.
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country..... 2

3. (a) PRINT FULL NAME **Samuel Homer Davis**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **Unknown**

4. Sex **Male** 0 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Wanda Davis**
 6. (c) Age of husband or wife if alive **22** years

7. Birth date of deceased **November 7 1914**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 10 29 hr. min.

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

10. Usual occupation **Shoe worker**

11. Industry or business

MOTHER FATHER { 12. Name **Oscar Davis**

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

14. Maiden name **Ernie Corzine**

15. Birthplace **Balcom Illinois** /
(City, town, or county) (State or foreign country)

16. (a) Informant **Carlis Davis**

(b) Address **Anna, Ill.**

17. (a) **Removal** (b) Date thereof **10-8-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anna, Illinois**

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

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

19. (a) **OCT 10 10 11 (b)** **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **6**
 year **1944** hour **9:20** minute **A.** M.

21. I hereby certify that I attended the deceased from **Oct 3** 19**44** to **Oct 6** 19**44**
 that I last saw h. alive on **Oct 6** 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart failure**
 Duration **1 da**

Due to **Peritonitis, acute spreading** 7 da

Due to **Thrombo-phlebitis, left leg** 4 yrs

Other conditions. **129**
(Include pregnancy within 3 months of death)

Major findings: **None**
 Of operations

Of autopsy **None**
 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?
(Specify type of place)

While at work? _____ Means of injury **0**

23. Signature **Deland Kieffer** (M. D. or other)
 Address **4500 Olive** Date signed **10/7/44**

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

079

8607
1098

8607
1098

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 *John Agoroski*
.....
Licensed Embalmer No. *2398*
.....
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.