

FILED FEB 5 1945

Primary Registration District No. 3063

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

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days 5 hrs.  
(Specify whether  
 In this community 5 years  
years, months or days)

3. (a) PRINT FULL NAME ALFRED M. DAVIS  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Separated  
 6. (b) Name of husband or wife Annie Davis  
 6. (c) Age of husband or wife if alive ? years  
 7. Birth date of deceased December 5 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>1</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Yardman

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name William Davis  
 13. Birthplace ? Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Martha Jones  
 15. Birthplace ? Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis County Hospital  
 (b) Address 601 So. Brentwood Blvd.

17. (a) Burial (b) Date thereof 1-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixon, Missouri

18. (c) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 9 1945 (b) E. S. McLauran  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town Carsonville  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 8508 Katherine Avenue  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day Seventh  
 year 1945 hour Eight minute 50 P.M.  
 21. I hereby certify that I attended the deceased from 1/5/45  
 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 1945  
 that I last saw him alive on 1/7  
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Arteriosclerotic - Hypertensive  
C-V Heart Disease

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  
 Signature St. Morris Alex M.D.  
 Address St. Louis County Hosp. Date signed \_\_\_\_\_

KEB 8 1945

**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 *Robert W. Shapiro*

Licensed Embalmer No. *1861*

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.**