

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

18323

U. S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4263**

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:
JEWISH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 2 DAY
(Specify whether years, months or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State..... MISSOURI (b) County..... 12

(c) City or town..... POPLAR BLUFF
(If outside city or town limits, write "RURAL") 7

(d) Street No.....
(If rural, give location) N.R. 3

(e) Citizen of foreign country?..... (Yes or No) _____

If yes, name country.....

3. (a) PRINT FULL NAME..... LEROY DAVIS

3. (b) If veteran, name war.....
3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 4th
year 1946 hour 1 minute 18 A.M.

21. I hereby certify that I attended the deceased from May 1st, 1946, to May 4th, 1946
that I last saw him alive on May 3, 1946
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife..... NELLE P.

6. (c) Age of husband or wife if alive..... 52 years

7. Birth date of deceased..... JULY 21 1890
(Month) (Day) (Year)

Immediate cause of death.....
Hypertensive Heart Disease
Nephritis, Chronic

Due to.....

Due to.....

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>9</u>	<u>13</u>	hr. _____ min. _____

Other conditions (include pregnancy within 3 months of death).....

Major findings:
Of operations.....

Of autopsy.....

9. Birthplace..... SPRINGFIELD MO
(City, town, or county) (State or foreign country)

10. Usual occupation..... BARBER

11. Industry or business.....

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?.....

MOYER FATHER

12. Name..... DR. W. B. DAVIS

13. Birthplace..... BUFFALO MO
(City, town, or county) (State or foreign country)

14. Maiden name..... MARTHA HALE

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

23. Signature..... Albert Kaplan (M. D. or other) _____
Address..... 607 N. Grand Date signed 5-4-46

16. (a) Informant..... MARTHA D. ANDREWS

(b) Address..... HARRISONVILLE, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof..... 5-6-1946
(Month) (Day) (Year)

(c) Place: burial or cremation..... POPLAR BLUFF MO

18. (a) Signature of funeral director..... GREER-CROY-FITCH FUNERAL

(b) Address..... POPLAR BLUFF MO

19. (a) MAY 11 1946 (Date received local registrar) J. F. Brudell (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

KAPLAN

4263

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 Ray E. Pampell
Licensed Embalmer No. 5881
P. O. Address St. Louis Mo

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.