FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 9 1947 #70061

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14987

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 4265

1. PLACE OF DEATH:

(a) County

(b) City or town: St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis city Hospital, Max Starkloff Memorial
(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: Missouri (b) County

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

(d) Street No.: 1636 Mississippi
(If rural, give location)

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

If yes, name country

2317 90

3. (a) PRINT FULL NAME: SAMUEL DAVIS

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

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Lucretia Davis

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

7. Birth date of deceased: July (Month) 24 (Day) 1862 (Year)

8. AGE:

Years	Months	Days	If less than one day
84	9	1	hr. min.

9. Birthplace: New York
(City, town, or county) (State or foreign country)

10. Usual occupation: Old Age Pensioner

11. Industry or business

FATHER
12. Name: Waterman L. Davis
13. Birthplace: New York
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Eliza Unknown
15. Birthplace: New York
(City, town, or county) (State or foreign country)

16. (a) Informant: Paul Davis
(b) Address: 3539 Park Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Fredericktown, Mo.

18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.

19. (a) APR 25 1947 (Date received local registrar) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25th year 1947 hour 4:15 minute A. M.

21. I hereby certify that I attended the deceased from 4-6-47, 19..., to 4-25-47, 19...; that I last saw him alive on 4-25-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Aortic aneurysm	5 yrs
Due to: Arteriosclerotic Ht Disease	10 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autops.:

PHYSICIAN
Underline the cause of 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? (e) Means of injury

23. Signature: George W. Smith (M. D. or other)
Address: 1515 Lafayette Date signed: 4-25-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Henry W. Bramm

Licensed Embalmer No. 4200

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w 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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4264

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:

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

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

3. (a) PRINT FULL NAME Samuel Davis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 24 1862
(Month) (Day) (Year)

8. AGE: Years 84 Months Days Unless than one day hr. min.

9. Birthplace N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-25-47 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL 25 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

14987