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MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20790
5381
Registrar's No.

FILED JUN 21 1948
318

Registration District No. 318 Primary Registration District No. 1003

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:
Homer G Phillips 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 Missouri (b) County.....

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

(d) Street No. 4117 Delmar
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3: (a) PRINT FULL NAME Frank Davis

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

4. Sex M 5. Color or race col 6. (a) Single, widowed, married, divorced S 0

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1948 hour 10 minute 5 P. M.

21. I hereby certify that I attended the deceased from June 6, 19 48 to June 9, 19 48
that I last saw him alive on June 9, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Undet.

Due to.....

Due to.....

Other conditions None
(Include pregnancy within 3 months of death)

8. AGE: Years About 49 Months Days If less than one day hr. min.

9. Birthplace Macon, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

Major findings:
Of operations.....

Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name Wm Davis

13. Birthplace Macon, Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Corine Sledge

15. Birthplace Macon, Miss.
(City, town, or county) (State or foreign country)

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 Oscar L Daniels (M. D. or other)
Address 2601 N Whittier Date signed 6/10/48

16. (a) Informant Mary Kennedy Ballard
(b) Address 4117 Delmar

17. (a) Burial, cremation, or removal Washington West Park Cem
(b) Date thereof 6 14 48
(Month) (Day) (Year)

(c) Place of burial or cremation.....

18. (a) Signature of funeral director A. J. Becklund
(b) Address 413 9th St St. Louis

19. (a) JUN 14 1948 (b) J. J. Braddock
(Date received local registrar) (Registrar's signature)

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 Vera F. Wilson

Licensed Embalmer No. 4435

P. O. Address 2618 Bally

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.