

#99357

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2593

318

State File No. 317

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>#5 N. 9th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.0</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u>		b. (Middle) <u>P</u>		c. (Last) <u>DAVIS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11th, 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Jan. 22, 1883</u>	
9. AGE (In years) (Month) (Day) (Year) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Montrose, Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>George W. Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Amazona Oman</u>		14. NAME OF HUSBAND OR WIFE <u>Emma E. Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Theodore Davis, Montrose, Iowa.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the Liver</u> ANTECEDENT CAUSES DUE TO (b) <u>Gastro-Intestinal Bleeding</u> DUE TO (c) <u>Thrombocytopenia</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>38 1/2</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1/5/49</u> , 19 <u>49</u> , to <u>1/11/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1/11/49</u> , 19 <u>49</u> , and that death occurred at <u>4:20A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>James G. McDaniel</u> (Degree or title)				23b. ADDRESS <u>1515 Lafayette Ave.</u>		23c. DATE SIGNED <u>1/11/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-11-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fort Madison, Iowa.</u>		24d. LOCATION (City, town, or county) (State) <u>Fort Madison, Iowa.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 11 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lassiter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe - St. Louis, Mo.</u>			

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Robert M Murray

Signed _____
Student Embalmer

Licensed Embalmer No. 3749

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.