

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 21 1957

37334

STATE FILE NUMBER 9409

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

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2290 2769 A Caroline		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT DAVIS			First	Middle	Last	
4. DATE OF DEATH OCT. 15, 1957		Month	Day	Year		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6 1887	9. AGE (In years at birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (City and state or country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Joe Davis		13b. MOTHER'S MAIDEN NAME Manda Campbell		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, None (down) (If yes, give year or dates of service))		16. SOCIAL SECURITY NO. 422-18-1971	17. INFORMANT Address Rosevelt Davis 2769 A Caroline			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INTRACEREBRAL HEMORRHAGE, SUSPECTED.					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) HYPERTENSIVE VASCULAR DISEASE				
		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES MELLITUS WITH ACIDOSIS 200X					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10/3/57 to 10/5/57 and last saw her alive on 10/5/57 Death occurred at 2:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Robert F. Owen, M. D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 10/7/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-11-57	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Livingston, Ala.		
24. FUNERAL DIRECTOR S. J. Watson		ADDRESS 2769 Chouteau	25. DATE RECD. BY LOCAL REG. OCT 9 '57	26. REGISTRAR'S SIGNATURE Paul Smith MD MOB		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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.

Student
Signature of Student Embalmer

Signed *S J Watson*

Licensed Embalmer No. *2698*
P. O. Address *2749 Chestnut*

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 embalmed by a-STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.