

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037722

STATE FILE NUMBER
10433

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Saint Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Saint Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP. #1.</i>		Length of stay in lb <i>229</i>	d. STREET ADDRESS (If outside, give location) <i>2624 Rear Market St.</i> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>HENRY DAVIS</i>			4. DATE OF DEATH Month Day Year <i>OCT. 29, 1958</i>		
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5. SEX <i>Male 3</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-23-1889</i>	9. AGE (In years last birthday) <i>68</i>	IF UNDER 1 YEAR Months Days <i>11 6</i>	IF UNDER 24 MRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pensioner</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Columbus, Mississippi</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>Dan Davis</i>	13b. MOTHER'S MAIDEN NAME <i>Harriett ?</i>	14. NAME OF HUSBAND OR WIFE <i>Mrs. Bessie Davis</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <i>Yes World War # 1</i>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Mrs. Ruth Davis 3951a Cook Avenue</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Bilateral cortical infarcts of kidneys 603X</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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
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21. I attended the deceased from <i>10/26/58</i> to <i>10/29/58</i> and last saw her alive on <i>10/29/58</i> Death occurred at <i>9:10A.M</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Leo T. Moore MD</i>	22b. ADDRESS <i>1515 LAFAYETTE AVE</i>	22c. DATE SIGNED <i>10/29/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>11-4-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Jefferson Barracks, Mo.</i>
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24. FUNERAL DIRECTOR <i>P. B. Moore</i>	ADDRESS <i>1221 N. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>OCT 3 1958</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, m.d</i> <i>a c m</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Vertical text on the left margin: All diseases in Part I must be causally related.

1. Name of Deceased

2. Date of Death

3. Place of Death

4. Name of Funeral Home

5. Name of Licensed Embalmer

6. License No.

7. Name of Student Embalmer

8. License No.

9. Name of Employer

10. Address

11. City

12. State

13. Zip

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 *Verene Thomas*

Licensed Embalmer No. 4755

P. O. Address 1221 N. Grand Bl

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.