

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019926  
STATE FILE NUMBER

ED JUN 9 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1530

300  
-57

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves, Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>46070 Webster Groves</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glenwood Home &amp; Hospital</b> Length of stay <b>8 days</b>		d. STREET ADDRESS (If outside, give location) <b>43 Tulip Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Mae</b> Last <b>Davis</b>			4. DATE OF DEATH Month <b>6</b> Day <b>3</b> Year <b>59</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881 2-5-1889</b>	9. AGE (In years last birthday) <b>70-78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Cincinnati, Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Eugene Kroth</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Fruit</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel K Davis</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If yes, give date of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>E.F. Davis</b> Address <b>43 Tulip Drive</b>
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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) <b>Cardiac insufficiency and Anemorrhagia</b> <b>Carcinoma of liver</b> DUE TO (b) <b>Carcinoma of liver</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Apr. 2 weeks</b> <b>Apr. 2-3 Mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <b>ITEM 8,9 CORRECTED</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	BY: 1. AFFIDAVIT OF Informant <b>Enlightened ext. dated 2-17-1951</b> 2. DOCUMENT <b>Marriage license</b>
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Webster</b> COUNTY <b>St. Louis</b> STATE <b>MO.</b>
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21. I attended the deceased from **5-26-59** to **6-3-59** and last saw her alive on **6-3-59 AM**.  
Death occurred at **1:40 PM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Thomas T. Hey</b> (Degree or title) _____	22b. ADDRESS <b>1300 Grant Rd. Webster</b>	22c. DATE SIGNED <b>6-4-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-5-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove Cemetery</b>	23d. LOCATION (City, <b>Webster</b> (State) <b>MO.</b> ) <b>Cincinnati Ohio</b>
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24. FUNERAL DIRECTOR <b>Parker-Aldrich Webster</b> ADDRESS <b>Grove s Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-4-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use only standard form. All diseases in Part I must be causally related.

6951 8 1400 SA

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 *Leslie Welch* .....

Licensed Embalmer No. *4395* .....

P. O. Address *Walter Brown* .....

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.