

MURI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

59-033725

FILED VS SEP 16 1959

2 8194

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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, MISSOURI		Length of stay in lb 36 yrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4264 W. Belle Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEONA NMN DAVIS				4. DATE OF DEATH Month Day Year SEPTEMBER 1 1959			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/26/01	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (City and state or country) Jefferson Co., Ark.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Ulysses Gates			13b. MOTHER'S MAIDEN NAME Elizabeth Hall		14. NAME OF HUSBAND OR WIFE William Davis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Ben H. Gates		Address 4264 W. Belle Pl.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM						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) CONGESTIVE HEART FAILURE						6-7 YEARS	
DUE TO (c) RHEUMATIC HEART DISEASE						10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)					
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	
21. I attended the deceased from APRIL 11, 1951 to SEPT. 1, 1959 and last saw her/him alive on SEPT. 1, 1959 Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) H. Bradley M. D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 9/2/59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/9/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) St. Louis County, Mo.			
24. FUNERAL DIRECTOR Charles J. Gates			ADDRESS 4107 Finney Ave.	25. DATE RECD. BY LOCAL REG. SEP 3 1959	26. REGISTRAR'S SIGNATURE Harold Smith M.D.		

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 *Gupton Lewis*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Ave

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.