

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032382

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8190**

FILED SEP 10 1962

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| 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 | | Length of stay in 1b 40 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 City Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4135 Tholozan Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Eliza Middle (Liza) Last Davis | 4. DATE OF DEATH Month August Day 22 Year 1962 |
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| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-20-1878 | 9. AGE (last birthday) 83 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Unknown Knapp | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR (deceased) Address William E. Davis |
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| 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. No | 17. INFORMANT Roy L. Davis 4135 Tholozan |
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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) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) 331x | |
| 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 |

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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Paul J. Simon (Degree or title) Physician | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 8-23-62 |
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|-------------------------------------------------------------|-------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8-24-1962 | 23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
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| 24. FUNERAL DIRECTOR'S NAME AND ADDRESS McLaughlin Funeral Home, Inc. 2301 Lafayette Avenue | 25. DATE RECD. BY LOCAL REG. 8-23-1962 | 26. REGISTRAR'S SIGNATURE Loal Smith, M.D. |
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VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 James R. Chapman

Licensed Embalmer No. 4550

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