

Registration District No. **86**Primary Registration District No. **3017**Registrar's No. **134**

## 1. PLACE OF DEATH:

(a) County **COOPER**  
 (b) City or town **BOONVILLE**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**821 MORGAN STREET**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **40 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MRS DELLA MAY DAVIS**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **MARRIED**  
 6. (b) Name of husband or wife **GEORGE DAVIS** 6. (c) Age of husband or wife if alive **40** years  
 7. Birth date of deceased **NOVEMBER 13 1897**  
 (Month) (Day) (Year)

8. AGE: Years **45** Months **11** Days **8** If less than one day hr. min.

9. Birthplace **QUINCY ILLINOIS**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**11. Industry or business **HOME**

MOTHER FATHER  
 12. Name **JAMES BROWN**  
 13. Birthplace **QUINCY ILLINOIS**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **UNKNOWN**  
 15. Birthplace **UNKNOWN UNKNOWN**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **GEORGE DAVIS**  
 (b) Address **BOONVILLE, MO.**

17. (a) **BURIAL** (b) Date thereof **OCT. 21-1943**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**18. (a) Signature of funeral director **STEGNER & KOENIG**(b) Address **BOONVILLE, MO.**

19. (a) **Oct 21-43** (b) **Archas Swap**  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER**  
 (c) City or town **BOONVILLE**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **821 MORGAN STREET**  
 (If rural, give location)  
 (e) Citizen of foreign country? **NO** (Yes or No)  
 If yes, name country **✓**

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **19**  
 year **1943** hour **7** minute **00** - P.M.

21. I hereby certify that I attended the deceased from **Oct 16 1943** to **Oct 19 1943**  
 that I last saw her alive on **Oct 16, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Pelvic Cancer** Duration **7 mo**

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings: **none** PHYSICIAN  
 Of operations.....  
 Of autopsy..... **none**  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify).....  
 (b) Date of occurrence.....  
 (c) Where did injury occur?..... (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....  
 23. Signature **J. C. Beckett** (M. D.)  
 Address **Boonville mo.** Date signed **10-21-43**

11-3-43

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *James W. Stegner*.....

Licensed Embalmer No. *3780*.....

P. O. Address..... *Boonville, 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 this body is not embalmed, fact should be so stated above.

Registration District No. *82*

Primary Registration District No. *3017*

Registrar's No. *134*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County *Cooper*  
 (b) City or town *Boonville*  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community.....  
years, months or days)

3. (a) PRINT FULL NAME *Della May Davis*  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *B*  
 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife.....  
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased *Nov 12 1885*  
(Month) (Day) (Year)

8. AGE: Years *45* Months *11* Days *8*  
If less than one day, min.

9. Birthplace.....  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....  
(City, town, or county) (State or foreign country)

14. Maiden name.....  
(City, town, or county) (State or foreign country)

15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant.....  
 (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....  
(Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Nov* 19 *19*  
 year *43* hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from..... 19.....  
 that I last saw him..... alive on..... 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death *uterine cancer* Duration.....

Due to *uterine in origin* 6 mo.

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work?.....  
(Specify type of place) (c) Means of injury.

23. Signature *J. Beckett* (M. D. or other).....  
 Address *Boonville, Mo* Date signed *11-6-43*

SUPPLEMENTARY

34504