

No. 2  
-12-45  
5-17-39  
I X47070

State File No. \_\_\_\_\_

FILED FEB 17 1947 318

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **1223**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1421 St. Louis Ave. J  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Morehouse  
(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 Feb. day 5  
year 1947 hour 9:00 minute \_\_\_\_\_ a. M.

21. I hereby certify that I attended the deceased from  
Jan. 1 1947 to Feb. 5 1947  
that I last saw her alive on Jan. 29 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiomyopathy  
Duration 4 yrs

Due to \_\_\_\_\_  
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)  
(e) Means of injury \_\_\_\_\_

23. Signature J. C. Cream (M. D. or other) M.D.  
Address 12504 N 14th St Date signed 2-5-47

3. (a) PRINT FULL NAME Bonnie Dot Davis

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Thomas Davis 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 29 1895  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51 9 6 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Beatrice Binkley

(b) Address 1421 St. Louis Ave.

17. (a) Burial (b) Date thereof 2-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kennett, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 2-5-1947 (b) J. J. Bredenk  
(Date received local registrar) (Registrar's signature)

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

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**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.....

*Henry M. Brammer*

..... Licensed Embalmer No. *4200*.....

P. O. Address.....

**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.**