

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14986**
Registrar's No. **3835**

FILED APR 21 1947

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2013 South Third Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Life**
years, months or days

3. (a) PRINT FULL NAME **RONALD ROY DAVIS**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **December 19, 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 3 21 hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Roy Davis**

13. Birthplace **New Madrid, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Lorene Schackelford**

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

16. (a) Informant **Lorene Davis**

(b) Address **2013 South Third Street**

17. (a) **burial** (b) Date thereof **4-12-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Hope Cemetery**

18. (a) Signature of funeral director **A.W. McLaughlin**

(b) Address **2301 Lafayette Avenue**

19. (a) **APR 11 1947** (b) *J.D. Bredek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2013 South Third Street** **2379**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **10th**
year **1947** hour **11:12** minute **0** M.

21. I hereby certify that I attended the deceased from **April 3rd**
1947, to **April 12th**, 19**47**
that I last saw him alive on **April 10th**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho-pneumonia** Duration **2 days**
Due to **Whooping Cough.**

Due to **Whooping Cough.**
Other conditions **Measles, Bacterial** Duration **1 day**
(Include pregnancy within 3 months of death)

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

22. If death was due to external causes, fill in the following: **no**

(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)
Means of injury _____

23. Signature *J.D. Bredek* (M.D. or other) **M.D.**
Address **2105 So Broadway** Date signed **4/12/47**

Cooper

Wm

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..... *L. K. Cooper*.....

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette St*

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.