

Registration District No. **43**

Primary Registration District No. **3007**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **BUTLER**  
(b) City or town **POPLAR BLUFF, MO.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **BRANDON** **10**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **48 days**  
(Specify whether years, months or days) **2 Mo.**

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Butler** **12**  
(c) City or town **Poplar Bluff** **3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **937 Gardner St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

**3. (a) PRINT FULL NAME** **BONNIE INEZ (WARREN) JAVIS**

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. **190-18-1240**

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

(b) Name of husband or wife **Paul Javis** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**24 8 21** hr. min.

9. Birthplace **WAYNE, Co** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **Housewife**

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

12. Name **John H. Warren**

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

14. Maiden name **Stella Dykeman**

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

16. (a) Informant **Paul Javis**  
(b) Address **Williamsville, Mo.**

17. (a) (b) Date thereof **July 18, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Logan**

18. (a) Signature of funeral director **Lloyd Russell**  
(b) Address **Osgott Ark.**

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **July** day **15**  
year **1944** hour **11** minute **45 p.** M.

21. I hereby certify that I attended the deceased from **May 22**, 19**44** to **July 15**, 19**44**  
that I last saw her alive on **July 15**, 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute nephritis** Duration **5-20-44**

Due to **Hypertension** **1 yr.**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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, or industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **[Signature]** (M. D. or other) **0**  
Address **Poplar Bluff Mo.** Date signed **7-27-44**

**PHYSICIAN**  
Underline the cause to which death should be based statistically.

MOTHER FATHER

FEB 20 1948

20 1948

NOV 20 1947

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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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. aug

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Papley Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Brandon  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 48 days  
(Specify whether

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Bonnie J. W. James

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 July year 1944 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death acute nephritis

Due to hypertension Chronic nephritis 5-20-44  
Jan. 44

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

MOTHER FATHER

USE CHARITABLE RECORD IN PLACE OF SUPPLEMENTAL RECORD

24206