

FILED MAY 2 1946

STANDARD CERTIFICATE OF DEATH
1003

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **3723**

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:
Homer G. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **42 Mins.**
1 Da. 8 Hrs.
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1708 Franklin**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

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

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month **3** day **25**
 year **1946** hour **8** minute **26 A.M.**
 21. I hereby certify that I attended the deceased from **11:44 P. M.**
3 - 23, 19 **46** to **8:26 A.M.**, **3-25**, 19 **46**
 that I last saw her alive on **3 - 25**, 19 **46**
 and that death occurred on the date and hour stated above.

4. Sex **Female**
 5. Color or race **Negro**
 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 **3 23 46**
 (Month) (Day) (Year)

Immediate cause of death _____
Prematurity
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings:
 Of operations _____
 Of autopsy _____

8. AGE:
 Years _____ Months _____ Days **1**
 If less than one day **8 hr. 42 min.**

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name **Leon John Bavis**
13. Birthplace **Meridian Mississippi**
 (City, town, or county) (State or foreign country)
14. Maiden name **Fannie Mae Flynn**
15. Birthplace **Blytheville Arkansas**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Arthur M. Sheward, R.N.**
 (b) Address **2601 N. Whittier Street**

17. (a) **Buried** (b) Date thereof **APR 20 1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of general director **V. B. Hudson**
 (b) Address **City Health Dept.**

19. (a) **APR 20 1946** **J. F. Bredek**
 (Date received by registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
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22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 Where did injury occur? _____ (City or town) (County) (State)
 (c) 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 **C. P. Danovich** (M. D. or other) **XXX**
 Address **2601 N. Whittier** Date signed **4-20-46**

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

10000

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 comply with the above constitutes grounds for revocation of license.)

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