

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22579
Registrar's No. 5685

Registration District No. 318

Primary Registration District No. 1003

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: Lutheran Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether
In this community Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME BONNIE RUTH PROFFITT

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S 0
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased June 6, 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
* * * 6 hr. 50 min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business.....

12. Name William Proffitt
13. Birthplace Kansas City, Missouri 0
(City, town, or county) (State or foreign country)
14. Maiden name Joyce Edgar
15. Birthplace ? Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant William Proffitt
(b) Address 915 LaSalle Street

17. (a) burial (b) Date thereof 6-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

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

(b) Address 2301 Lafayette Avenue

19. (a) JUN 9 1947 (b) J. T. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2646 Potomac Street (If rural, give location)
24 no
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7th
year 1947 hour 5:05 minute a M.

21. I hereby certify that I attended the deceased from June 6, 1947 to June 7, 1947
that I last saw her alive on June 7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration.....

Hydrocephalus
Acidodroplasia } congenital

Due to.....

Due to.....
Other conditions (Include pregnancy within 3 months of death) 157

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, in industrial place, in public place?.....

(Specify type of place)
While at work?..... (c) Means of injury.....

23. Signature Frank A. Bailey (M. D. or other) U.S.
Address 3108 So. Grand Date signed 6-8-47

Dr. Frank A. Bailey
3108 So. Grand Bl.

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.....

C. W. Cooper

Licensed Embalmer No. *3830*

P. O. Address.....

2301 Lafayette

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.