

No. 2
1/47
5-17-39

40734

FEDERAL BUREAU OF INVESTIGATION

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 27

National Office of Vital Statistics
FILED NOV 25 1947
Registration District No. 373

Primary Registration District No. 4544

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

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Maangua
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Schlichte Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: few hours (Specify whether
In this community few hours (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dallas
(c) City or town Conway
(If outside city or town limits, write "RURAL")
(d) Street No. R R # 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Bettie RAE DAVIS
3. (b) If veteran, name war -
3. (c) Social Security No. none

4. Sex 7 1 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased Oct. 2 1924
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
22 10 23 hr. min.

9. Birthplace Stone Co. Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name William R. Davis
13. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Laura R. Smart
15. Birthplace Texas Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. R. Davis
(b) Address Conway, Mo. R # 2

17. (a) Burial (b) Date thereof 8-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery, Lebanon

18. (a) Signature of funeral director W. E. Hobman
(b) Address Lebanon, Mo.

19. (a) 11-4-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25th
year 1947 hour 5 minute 50 P.M.
21. I hereby certify that I attended the deceased from 2 P.M.
5 Aug. 1947 to 5:50 P.M. 5 Aug. 1947.
that I last saw her alive on 5 Aug. 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death hemorrhage cerebral, acute, severe-

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 837A
Of operations
Of autopsy None

PHYSICIAN
Underline the cause of 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?
23. Signature [Signature] (M. D. or other)
Address Maangua, Mo. Date signed Aug 15-47

RECEIVED

District Health Officer No. 6,

District File Number 1147-1223

Date Filed 11-24-47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1111
Registrar's No. 52

Registration District No. 373 Primary Registration District No. 4044

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

1. PLACE OF DEATH: Webster

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

3. (a) PRINT FULL NAME Bette R. Davis

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 S

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

7. Birth date of deceased Oct 2 (Month) (Day) (Year)

8. AGE: 22 Years Months Days (If less than one day, hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 Oct year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Due to.....

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, 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.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

40734