

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Rural -- Gallatin township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: on highway # 10 east of North K. C.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay
 (c) City or town North Kansas City, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 1210 E 22nd St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Preston Cred Davis

3. (b) If veteran, name war _____ 3. (c) Social Security No. A87-16-2449

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Alpha McCanniss 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased May 24, 1917
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
22 4 9 hr. _____ min.

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

10. Usual occupation laborer - construction

11. Industry or business _____

12. Name John P. Davis

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

14. Maiden name Lizzie Ray

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

16. (a) Informant's own signature Benton Davis

(b) Address Lexington, Mo.

17. (a) Burial (b) Date thereof Sept 27-30
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director Morton Fung

(b) Address Mo Kansas City Mo.

19. (a) Dec. 1-1938 (b) Viola C Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23
 year 1939 hour 12 minute 30 AM.

21. I hereby certify that I attended the deceased from _____, 19____ 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 broken neck Duration _____

Due to automobile accident

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) accident

(b) Date of occurrence Sept 23, 1939

(c) Where did injury occur? North K.C. Clay Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public highway # 10
(Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature Catherine Meyer Date signed _____

Address Liberty Mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1938-1-10851

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DEC 12 1939

2/10/37

Sta by
Date

RECEIVED FILED
INDEX CARD RETURNED TO DISTRICT
DATE 2/6/37

FEB 6 1937

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 Howard L. Pissin

Licensed Embalmer No. 3605

P. O. Address Union St. No

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3935-6
Do not use this space.

1. PLACE OF DEATH
 (a) County Clay Registration District No. 197
 (b) Township Salfatin Primary Registration District No. 3276 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Preston Fred Davis
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Div

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>22</u>	<u>4</u>	<u>9</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Automobile accident Date of onset _____

Other contributory causes of importance: 2107W

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Automobile Date of injury Sept 23 1939
 Where did injury occur? On High way 168
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury Head on collision
 Nature of injury Crushed Chest

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Catheterize Weyoung case
 (Signed) Koberky (Address) Tras

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

