

FEB 26 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1080

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Kansas
 (b) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital No. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12-30 to 1-1-40
 (Specify whether
 In this community 2 days
 years, months or days)

8. (a) PRINT FULL NAME Infant Davis 120

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased 12 30 1939
(Month) (Day) (Year)8. AGE: Years 0 Months 0 Days 2 If less than one day hr. _____ min. _____9. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation None

11. Industry or business _____

12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Lorene Davis
15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address General Hospital No. 217. (a) Burial (b) Date thereof 1-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Field18. (a) Signature of funeral director M. M. Crowder(b) Address 11 C. St. Hosp.19. (a) Jan. 6, 1940 (b) M. M. Crowder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City,
 (If outside city or town limits, write "RURAL")
 (d) Street No. Florence Home
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 1
year 40 hour 3 minute 50 p. a. m.21. I hereby certify that I attended the deceased from 12-30, 1939 to 1-1- 1940;
that I last saw him alive on 1-1- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Broncho PneumoniaPrimary

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____23. Signature A. O. DeWine (M. D. or other)Address General Hospital #2 Date signed 1-4-40

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, above space should be left blank.