DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

OCT 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31149

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3712

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community 30 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 3718 College Avenue (If rural, give location)

(e) If foreign born, how long in U. S. A.? --- years.

3. (a) PRINT FULL NAME Mrs. Elizabeth Davis

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. Christppher C. Davis

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased September (Month) 30 (Day) 1863 (Year)

8. AGE: Years 76 Months 11 Days 23 If less than one day ___ hr. ___ min.

9. Birthplace Holt County (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation At Home 6

11. Industry or business --- 6

FATHER
12. Name Charles Mann
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant [illegible]
(b) Address St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Rulo, Nebraska

18. (a) Signature of funeral director O. H. Newcomb's Son
(b) Address 1401 Brush Creek Blvd.

19. (a) 9-24-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23rd year 1940 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from 1935, 19__, to Sept 23, 1940 that I last saw her alive on Sept 23, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Edema

Due to Myocardial Degeneration

Due to

Other conditions (Include pregnancy within 3 months of death) 93c

Major findings:
Of operations —
Of autopsy Yes

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 Hugh A. Gestring (M. D. ~~or other~~)
Address 303 Westminster Bldg Date signed 9-24-40

(Licensed Embalmer's Statement on Reverse Side)

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.....George M. Collie

Licensed Embalmer No.....3989

P. O. Address.....K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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