

FILED NOV 12 1940
Registration District No. 2839

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(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: 322 Marsington St. 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

John Davis

3. (b) If veteran, name war

3. (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

7. Birth date of deceased Unknown

8. AGE: Years About 68 Months Days If less than one day

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

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name

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

16. (a) Informant Mrs. Clark

(b) Address 1419 Tracy St.

17. (a) Removal (b) Date thereof 10/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence Home

18. (a) Signature of funeral director Ideal Funeral Home

(b) Address 1409 E. 12th St.

19. (a) 10-3-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1826 E. 16th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 25
year 1940 hour 10:08 minute A M.

21. I hereby certify that I attended the deceased from Deputy Coroner
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic fibrous myocarditis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy no (resp.)

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? _____

While at work? _____ (Specify type of place) (Means of injury) 1

23. Signature P. P. Richardson (M. D. or other)
Address 1832 Yale Date signed _____

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.