

No. 2
4-13-40
5-17-39
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FILED JAN 8 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41261
4654

State File No. _____
Registrar's No. _____

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
In this community 21 Yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert T. Davis
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mrs. Fannie M. Davis 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased January 3, 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation Stock Room

11. Industry or business McPike Drug Company

12. Name Amos W. Davis

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

14. Maiden name Sarah Youngblood

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

16. (a) Informant Mr. Park T. Davis

(b) Address 816 East 9th Street

17. (a) Cremation (b) Date thereof Dec. 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer
(b) Address 1401 Brush Creek Blvd.

19. (a) 12-7-40 (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
(If outside city or town limits, write "RURAL")
(d) Street No. No. 816 E. 9th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6th
year 1940 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from 11-15-40, 19 , to 12-6-40, 19 ;
that I last saw him alive on 12-6-40, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Diffuse carcinomatosis, probably primary focus in gall bladder

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy See above

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 Dwight R. Thorne (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hospital, K. C. Mo. Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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, fact should be so stated above.