

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

FILED JUL 19 1943
Registration District No. **149**

Primary Registration District No. **1002**

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: **General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 mo. 15 days**
(Specify whether In this community **Unknown** 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. **825 E. 13th**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Samuel Davis**

3. (b) If veteran, name war **✓ WW**
3. (c) Social Security No. **710**

4. Sex **Male** 5. Color or Race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **May B**
6. (c) Age of husband or wife if alive **✓** years
7. Birth date of deceased **Jan 1 1875**
(Month) (Day) (Year)

8. AGE: Years **68** Months **6** Days **21**
If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER {
12. Name **James Davis**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Emma Walker**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Oscar Trett**

(b) Address **906 E. 13th**

17. (a) **Removed** (b) Date thereof **7/6/43**
(Specify, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Hope Cemetery R.C. Mass**

18. (a) Signature of funeral director **Sue M. May**

(b) Address **2319 Removal**

19. (a) **7-8-43** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **2**
year **1943** hour **10** minute **10 P** M.

21. I hereby certify that I attended the deceased from **January 17 1943** to **July 2 1943**
that I last saw him alive on **July 2 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **hypostatic pneumonia** ✓
Duration _____

Due to _____

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) _____

(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)
(b) Means of injury _____

23. Signature **Wm. R. Thoms** (M. D. or other) _____

Address _____ Date signed _____

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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..... *Ray E Snow*

Licensed Embalmer No..... *2560*

P. O. Address..... *K @ M*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2966

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Russell city
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased Jan 1
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days _____ (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death hypostatic / pneumonia (Broncho)

Due to _____

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) _____

(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 Henry R. Thom (M. D. or other) _____

Address Meramec Date signed _____

SUPPLEMENTARY

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Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-23799