

Registration District No. 1944/49

Primary Registration District No. 1002

Registrar's No. 5435

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution 1614 E. 13th home 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 30 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME EZEKIEL DAVIS

3. (b) If veteran, name war NO

3. (c) Social Security DONT KNOW

4. Sex MALE

5. Color or race NEGRO

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

6. (b) Name of husband or wife LILLIAN DAVIS

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased OCT 17 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>2</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation SHOE SHINER

11. Industry or business 1103 1/2 BROADWAY

12. Name WILLIS DAVIS

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

14. Maiden name DONT KNOW

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

16. (a) Informant LILLIAN DAVIS (WIDOW)

(b) Address 1614 E. 13

17. (a) BURIAL
(Burial, cremation, or removal)

(b) Date thereof 12-24-43
(Month) (Day) (Year)

(c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director Flynn + Greenstreet

(b) Address 1819 E. 15 KE MO

19. (a) 12-20-43
(Date received local registrar)

N. E. Brown
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County JACKSON

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

(d) Street No. 1614 E. 13th
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 - Day 20 - Year 43
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 12-20-1943 to 12-20-1943
that I last saw him alive on 12-20-1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to myocarditis

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations 93rd

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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? _____

23. Signature [Signature]
(Specify type of place) (M. D. or other)

Address 2200 E. 18th Date signed 12-24-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

W. G. Flynn

Licensed Embalmer No.

2211

P. O. Address

1819 E. 15th

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.