

FILED JAN 19 1944
Registration District No. **1002**

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 No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12-8-43-12-23-43**
(Specify whether
In this community **22 Years**
years, months or days)

3. (a) PRINT FULL NAME

ARCHIE DAVIS

3. (b) If veteran, name war

3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or Race **Negro**

6. (a) Single, widowed, married, **2 divorced, Widower**

6. (b) Name of husband or wife

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

7. Birth date of deceased **October 4 1887**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 2 19 hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business

12. Name **Bragg Davis**

13. Birthplace **Austin Texas**
(City, town, or county) (State or foreign country)

14. Maiden name **Sidney Henry**

15. Birthplace **Austin Texas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **General Hospital No. 2**

17. (a) **Burial** (b) Date thereof **12-31-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Winedn Cem Adkins Bros.**

18. (a) Signature of funeral director **2000 E. 12th St. K.C. Mo.**

(b) Address **2000 E. 12th St. K.C. Mo.**

19. (a) **Dec 31, 1943** (b) **J.B. 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. **1224 Paseo 2nd Fl. N.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **23**
year **1943** hour **9:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **December 8**
43 to **December 23** 19**43**.

that I last saw him alive on **December 23** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure** Duration _____

Due to **Hypertensive Heart Disease**

Due to _____

Other conditions (include pregnancy within 3 months of death) **93d**

Major findings: Of operations _____

Of autopsy **Same as 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? _____

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

23. Signature **J.B. Brown** (M.D. or other) _____
Address **1402 #2 600 E 22** Date signed **12/24/43**

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

2
43
39
35697

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.....

A. T. Moore

Licensed Embalmer No.....

948

P. O. Address.....

Kansas City Mo

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.