

FILED JUN 19 1944

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 603

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 1/2 yrs
In this community not contained in records
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2014 50 South
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Addie L. Davis

3. (b) If veteran, name war no 3. (c) Social Security No. nil

4. Sex female 5. Color or race wh 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 84 Months Days If less than one day
hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER { 12. Name Unknown
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant hospital records
(b) Address St. Joseph, Mo

17. (a) Burial (b) Date thereof 6/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation State Hosp for Ind & V. Men

18. (a) Signature of funeral director Heston - Nichols
(b) Address 319 So 10th St

19. (a) 6/13/44 (b) Deleon J. Pickle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1944 hour 5:55 minute P. M.

21. I hereby certify that I attended the deceased from March 1
1944 to June 9, 19 44
that I last saw her alive on June 9, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Arteriosclerosis

Due to Senility

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

Major findings:
Of operations 93el
Of autopsy

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) (e) Means of injury

23. Signature [Signature] (M. D. or other)
Address State Hospital No 2, St. Joseph Date signed 6/9/44

27 of 42
that is 4108
on

Handwritten notes at top right, possibly including "State of Ohio" and "No. 1710".

Address Davis

line

at

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.....

Not Embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Frank J. Brown

Licensed Embalmer No. 1710

P. O. Address.....

St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.