

FILED AUG 2 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23657

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2988

1. PLACE OF DEATH:
(a) County Jackson Mo.
(b) City or town J.C. Mo.
(c) Name of hospital or institution: K.C. TB Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr 16 d.
In this community 39 yr. (Specify whether 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. 554 Ash
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3. (a) PRINT FULL NAME Elsie E. Davidson
(b) If veteran, name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 17
year 1944 hour 10.50 minute P M.
21. I hereby certify that I attended the deceased from 7-1-43
1943 to 7-17 1944
that I last saw h. l. alive on 7-17 1944
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ethel
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased: 5 (Month) 7 (Day) 1886 (Year)

Immediate cause of death: Terminal Pneumonia Duration 2 days

8. AGE: Years 58 Months 2 Days 10 If less than one day hr. min.

Due to Carcinoma of Bronchus Rt 1 yr.

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

Due to

10. Usual occupation Laborer

Other conditions (Include pregnancy within 3 months of death) 47 C

MOTHER FATHER
11. Industry or business
12. Name Joseph Davidson
13. Birthplace Rock Hill Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Ann Wells
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: Of operations
Of autopsy same
Underline the cause to which death should be charged statistically.

16. (a) Informant Records K.C. TB Hosp
(b) Address K.C. 3 Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

17. (a) Burial (b) Date thereof 7/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

(b) Date of occurrence

18. (a) Signature of funeral director Geo. E. Carson
(b) Address Indef. Mo.

(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) (Means of injury)

19. (a) 7-19-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

23. Signature Matthew J. Roone (M. D. or other)
Address K.C. 3 Mo. Date signed 7/18/44

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

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 *Floyd Clauson*
Licensed Embalmer No. *2199*
P. O. Address *Miss*

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.