

FILED SEP 7 1944

Registration District No. 1002

Registrar's No. 3493

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Milner Hotel 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution unknown
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
 (c) City or town Kansas City MO
(If outside city or town limits, write "RURAL.")
 (d) Street No. Milner Hotel
9th. + Central
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country.....

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

(b) If veteran, name war NO 3. (c) Social Security No. none

4. Sex Male 5. Color or White
 6. (a) Single, widowed, married, divorced not

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

7. Birth date of deceased.....
(Month) (Day) (Year) 1902

8. AGE: Years 42 Months Days If less than one day
 hr. min.

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

10. Usual occupation 0

11. Industry or business not

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 Coroner office

(b) Address Kansas City MO

17. (a) Removal (b) Date thereof 8/27/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Libbyville Texas

18. (a) Signature of funeral director Parantine Bros.

(b) Address Kansas City MO

19. (a) 8-27-44 (b) N.E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
 year 1944 hour 11 minute 21 A.M.

21. I hereby certify that Dr. Grom attended the deceased from..... 19.....;
 that I last saw him..... alive on..... 19.....;
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Coronary occlusion
arterial thrombosis

Due to.....
 Due to..... 94W

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings.....
 Of operations.....
 Of autopsy see upon

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature C. S. Brown 38/2/44 (M. or other)
 Address..... Date signed.....

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

4838

3/31

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.....

Paul H. Rowe

Licensed Embalmer No. *2347*

P. O. Address: *Ill. C. 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.