

FILED NOV 13 1944

4301

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Vineyard Park Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community 20 years years, months or days)

3. (a) PRINT FULL NAME Edwin Daniel Davis

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Ina R. Davis

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Dec. 17, 1870  
(Month) (Day) (Year)

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

73 10 8 hr. min.

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Marion D. Davis

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

14. Maiden name Ellen Bordman

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

16. (a) Informant Mrs. Ina R. Davis

(b) Address 6400 East 16th Ter. K.C. Mo.

17. (a) Burial (b) Date thereof Oct. 28  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director John P. Sheil

(b) Address K.C. Mo.

19. (a) 10-27-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42

(c) City or town Kansas City, Mo. 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 6400 East 16th St Terrace ?  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25  
year 44 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from July 29 to Oct 25, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Edema 5 days  
Due to Myocarditis 1 1/2

Due to Coronary atherosclerosis

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 93 d.

Of operations: \_\_\_\_\_

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 J. Sheildon (M. D. or other) MD

Address 924 Walnut Date signed 10/27/44

**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..... *J. Pennell Sheld* .....

Licensed Embalmer No. .... 3625 .....

P. O. Address..... K.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.**