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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40059

FILED JAN 11 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5345

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: Wheatley Provident (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether

In this community 6 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas city (If outside city or town limits, write "RURAL") 977

(d) Street No. 2702 N. Sherman (If rural, give location) 14

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lizzie Mae Davis

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex 3 Female

5. Color or race negro

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

6. (b) Name of husband or wife Clyde C. Davis

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased 12 (Month) 17 (Day) 1921 (Year)

8. AGE:

Years	Months	Days	If less than one day
23	0	8	hr. min.

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

10. Usual occupation House Work

11. Industry or business at Home

FATHER
12. Name Joe Robinson
13. Birthplace Texas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sylvia Black
15. Birthplace Texas (City, town, or county) (State or foreign country)

16. (a) Informant Lizzie Black

(b) Address 2702 N. Sherman

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-3-'44 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Texas

18. (a) Signature of funeral director Mrs. J. W. Jones

(b) Address 440 State Ave

19. (a) 12-30-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 12 day 25 year 1944 hour 5 minute a M.

21. I hereby certify that I attended the deceased from Dec - 2 - 1944, to Dec - 25 1944 that I last saw her alive on Dec - 24 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to Virus Pneumonia lobar

Due to Intestinal Influenza

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 92 b

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Rivelliams (M. D. ~~or other~~)

Address 2636 - Brooklyn Date signed 12/28/44

(Licensed Embalmer's Statement on Reverse Side)

2636
Brooklin

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 Eugene English

Licensed Embalmer No. 4105

P. O. Address 440 State Ave. N

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.