

FILED AUG 4 1945  
Registration District No. **447**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **John L. Davis Jackson Mo**  
(b) City or town **Kansas City Mo**  
(c) Name of hospital or institution **714 Harrison**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **30 yrs**  
In this community **30 yrs**  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **714 Harrison**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

**JOHN L. DAVIS**

3. (b) If veteran, name war **unknown**

3. (c) Social Security No. **40**

4. Sex **Male**

5. Color or race **W**

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

6. (b) Name of husband or wife **unknown**

6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased

**Sept 12 1875**  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

**69**

**10**

**10**

hr. min.

9. Birthplace

**Meek mining Ford**  
(City, town, or county) (State or foreign country)

10. Usual occupation

**Retired**

11. Industry or business

**unknown**

12. Name

**unknown**

13. Birthplace

**Mo** (City, town, or county) (State or foreign country)

14. Maiden name

**11** (City, town, or county) (State or foreign country)

15. Birthplace

**11** (City, town, or county) (State or foreign country)

16. (a) Informant

**Wm Henry Meinert**

(b) Address

**3049 Roosevelt**

17. (a) Burial

**at Calvary**

(b) Date thereof

**7-24-45**  
(Month) (Day) (Year)

(c) Place: burial or cremation

**at Calvary**

18. (a) Signature of funeral director

**Wm B. Ketchum**

(b) Address

**1500 W. 12th**

19. (a) Date received local registrar

**7-24-45**

(b)

**Sheraldine Holmes**  
(Registrar's signature)

23. Signature

**Dr. Owen**

(M. D. or other)

Address

**Kansas City**

Date signed

**7/23/45**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**  
year **1945** hour **10:35** minute **a.m.**

21. I hereby certify that I attended the deceased from **Deputy** to **Coroner**  
that I last saw him alive on **July 22** 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death

**Coronary Sclerosis**

Due to

**Coronary Sclerosis**

Due to

**Senility**

Other conditions

**none 940**

Major findings:

Of operations **no op**

Of autopsy **no 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

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

MOTHER FATHER

**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.....

*Peter B. Linton*

Licensed Embalmer No. *4273*

P. O. Address *152 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.**