

S. No. 2
M-5-43
7-5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 21 1945

State File No. 37428
Registrar's No. 290

Registration District No. 146 Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural *Blue Springs*

(c) Name of hospital or institution: 8712 Independence

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

(d) Length of stay: In hospital or institution 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson *44*

(c) City or town Rural

(d) Street No. 8712 Independence Blvd.

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

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM THOMAS DAVIS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Isabelle

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec. 7, 1867

(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17 year 1945 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from March 1944 to Oct 17, 1945

that I last saw him alive on Oct 16, 1945 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>10</u>	<u>10</u>	hr. min.

Immediate cause of death Pulmonary edema

Due to Chronic myocardial insufficiency

Other conditions Bronchial asthma

(Include pregnancy within 3 months of death)

Duration 2 da

4 yr.

9. Birthplace Richmond Ky.

10. Usual occupation Star Route Owner

11. Industry or business Kansas City Star

MOTHER FATHER { 12. Name Samuel Davis

13. Birthplace Unknown

14. Maiden name Susan Hagle

15. Birthplace Richmond, Ky.

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Isabelle Davis

(b) Address 8712 Independence Ave.

17. (a) Burial (b) Date thereof 10.19/45

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son,

(b) Address Kansas City, Mo.

19. (a) 10-18-45 (b) James Ross

(Date received local registrar) (Registrar's signature)

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Virgil P. Hawkins (M.D. or other) N.O.

Address Independence, Mo. Date signed 10-18-45

1163

Dr. L. V. Hawkins

537 College St. No.
Rox

DEC 1 1945

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 ~~W. D. Blackman~~ *W. D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address *Rox, 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.