

FILED FEB 19 1946
Registration District No. **149**

Primary Registration District No. **1002**

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: **General Hospital #2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 hrs.**
(Specify whether years, months or days)
In this community **25 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1816 Grove**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Clarence Davis**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ruth** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **May 30, 1894**
(Month) (Day) (Year)

8. AGE: Years **51** Months **8** Days **0** If less than one day hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business **None**

MOTHER FATHER
12. Name **Frank Davis**
13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Laura Hunter**
15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **Medical Records Librarian**

(b) Address **General Hospital #2**

17. (a) **Removal** (b) Date thereof **2-5-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hillsdale, Kansas**

18. (a) Signature of funeral director **N. W. Thibault**

(b) Address **1520 N. 5th Street**

19. (a) **2-5-46** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **30**, year **1946** hour **8**: minute **20** A. M.

21. I hereby certify that I attended the deceased from **January 29**, 19 **46**, to **January 30**, 19 **46**

that I last saw him alive on **January 30**, 19 **46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

23. Signature **B. O. Turner** (M. D. or other)
Address **General Hospital #2** Date signed **1/30/46**

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

4560

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 Nathan W. Hatfield
Licensed Embalmer No. 2700
P. O. Address 1520 N. 5th St.

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.