

U. S. No. 2  
 FORM-5-43  
 Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
 THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

RURKES

State File No. \_\_\_\_\_  
 Registrar's No. 2741

**FILED** JUL 2 1946  
 149

Registration District No. 149 Primary Registration District No. 1002

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:  
(At home) 2643 Highland Ave. /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community Three Months

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2643 Highland Ave. 8  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Allen Davis  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. 335-03-1520

4. Sex Male 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Deliah Davis  
 6. (c) Age of husband or wife if alive Dec. years  
 7. Birth date of deceased July 21 1886  
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 25  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Wrightsville Ark. /  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

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

MOTHER FATHER  
 12. Name Wash Davis  
 13. Birthplace Don't Know  
(City, town, or county) (State or foreign country)  
 14. Maiden name Charlotte Waters  
 15. Birthplace Texas /  
(City, town, or county) (State or foreign country)

16. (a) Informant Essie Pleasant  
 (b) Address 2643 Highland Ave.

17. (a) Removal (b) Date thereof 6-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Chicago Ill.

18. (a) Signature of funeral director Wm. J. [Signature]  
 (b) Address 1905 [Address]

19. (a) 6-20-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16  
 year 1946 hour 10 minute 15 p. M.

21. I hereby certify that I attended the deceased from June 1 1946 to June 16 1946  
 that I last saw him alive on June 16 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Colic Peritonitis Duration 16 days

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions 108  
(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)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature D. M. Miller (M. D. or other) \_\_\_\_\_  
 Address 1605 E. 18th Date signed 6-20-46

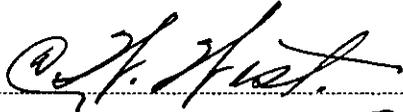
19095 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  


Licensed Embalmer No. 2710

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.**