

No. 2
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DEPARTMENT OF COMMERCE
STATE BOARD OF HEALTH OF MISSOURI

THE STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 27 1946 STANDARD CERTIFICATE OF DEATH

State File No. 27082

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3512

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:
1401 Virginia /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 23 days (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Kennon Eugene Davis

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

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased July - 20 - 1946
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
		<u>23</u>	hr. min.

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

10. Usual occupation None

11. Industry or business

12. Name Alf Davis

13. Birthplace North Little Rock Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Annie Mae Reed

15. Birthplace Little Rock Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Alf Davis

(b) Address 1401 Virginia, Kansas City, Mo.

17. (a) Burial (b) Date thereof 8/14/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director E. Sterling Bills

(b) Address 1212 Vine St., Kansas City, Mo.

19. (a) 8-14-46 (b) Steraldine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL") 3
 (d) Street No. 1401 Virginia
(If rural, give location) F
0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Months Aug day 13
 year 1946 hour 4 minutes 20 P.M.

21. I hereby certify that I attended the deceased from July 20
20 to Aug 13
 that I last saw him alive on Aug 13
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial
Pneumonia
 Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: 107
 Of operations
 Of autopsy

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
 23. Signature R. V. Miller M.D. or other
 Address 1203 Pratt Date signed 8/13/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.