

FILED APR 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8010

State File No.

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. # 1 D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since Aug 24-1948
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME William Walker Davis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Beal Davis 6. (c) Age of husband or wife if alive 9 years
7. Birth date of deceased mch 15 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>		<u>14</u>	hr. _____ min. _____

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

10. Usual occupation waiter

11. Industry or business _____

MOTHER FATHER

12. Name Walker Davis
13. Birthplace N.K.
(City, town, or county) (State or foreign country)
14. Maiden name Attie Monday
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Hosp. records
(b) Address _____

17. (a) Removal (b) Date thereof 3-29-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director C. F. Blackman & Son, Inc.
(b) Address 2825 Indep. Blvd., Kansas City, Mo.

19. (a) 3-29-1948 (b) Josie Morsell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2632 Myrtle
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mch. day 29
year 1948 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 28
1948 to mch 29 1948
that I last saw him alive on mch 28 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Paras

Due to Syphilis

Due to _____

Other conditions Latent bone involvement
(Include pregnancy within 3 months of death)

Major findings:
Of operations none done
Of autopsy no 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)
(c) Means of injury _____

Signature P. S. Tate (M. D. or other) _____

Address State Hosp. # 1 of Mo. Date signed 3-29-48

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed APR 7 1949

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. K. McFarland

Licensed Embalmer No. 4397

P. O. Address 2825 Indep. Blvd., 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.