

S. No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8662

FILED MAR 20 1948

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1056

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

18  
3  
8

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:  
705 THE PASEO  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community 30 YEARS years, months or days)

3. (a) PRINT FULL NAME MR. WILLIAM WALLACE DAVISSON

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. EVA DAVISSON

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

7. Birth date of deceased JUNE 14 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

87 8 21 1/2 hr. \_\_\_\_\_ min.

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

10. Usual occupation RETIRED

11. Industry or business FARMER

MOTHER FATHER { 12. Name NATHAN DAVISSON

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

14. Maiden name ELIZABETH LEEP

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

16. (a) Informant Mrs. Edythe Stoffer

(b) Address 9107 Holmes Street

17. (a) BURIAL (b) Date thereof MARCH 8, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director J. H. Newcomer's Son

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 3-8-48 (b) Edith Edeline Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY 48  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 705 THE PASEO 8  
(If rural, give location)

(e) Citizen of foreign country NO (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 6<sup>TH</sup>  
year 1948 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3/6  
1948 to 3/6 1948  
that I last saw him alive on 3/6 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 8 hours

Due to Hypertension Senility

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: 830

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 0

23. Signatory Edmund H. White (M. D. or other) \_\_\_\_\_  
Address Plaza Med. Bldg. Date signed 3/5/48

KC-2-48

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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: *Bernard J. Horan*  
Licensed Embalmer No. *4250*  
P. O. Address *NC 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.**

*St Lukes*