

FILED NOV 16 1948

Registration District No. **249**

Primary Registration District No. **1002**

Registrar's No. **1401**

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: **ROBINSON CLINIC**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 DAY**
(Specify whether years, months or days)
In this community **1 DAY**

3. (a) PRINT FULL NAME **MR. EDGAR R. DAVIES**

3. (b) If veteran, name war **SPANISH AMERICAN** 3. (c) Social Security No. **347-01-3355**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MRS. MARY. DAVIES** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **SEPT. 12 1872**
(Month) (Day) (Year)

8. AGE: Years **75-** Months **1** Days **16** If less than one day hr. min.

9. Birthplace **NEW YORK**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED**

11. Industry or business

12. Name **REV. PHILLIP L. DAVIES** 13. Birthplace **WALES, ENGLAND**
(City, town, or county) (State or foreign country)

14. Maiden name **SARAH THOMAS** 15. Birthplace **WALES, ENGLAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. MARY. DAVIES**
(b) Address **429 SO. ELM OTTAWA, KS.**

17. (a) **REMOVAL** (b) Date thereof **10-29-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **OTTAWA, KS.**

18. (a) Signature of funeral director **STINE & McCLURE**
(b) Address **KANSAS CITY, MO.**

19. (a) **10-29-48** (b) **Seraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **KANSAS** (b) County **999**
(c) City or town **OTTAWA** **14**
(If outside city or town limits, write "RURAL")
(d) Street No. **429 SO. ELM** **0**
(If rural, give location) **2**
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **NO**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT.** day **28**
year **1948** hour **8** minute **50 A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia** Duration _____

Due to _____

Due to _____

Other conditions **Deputy Coroner**
(Include pregnancy within _____ months of death)

Major findings: Of operations _____

Of autopsy **See Above**

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 **A. E. Upsher** (Specify date of place) **A. E. Upsher** Means of injury **6**

23. Signature **A. E. Upsher** (M. D. or D.O.) **10/28/48**
Address **2800 Main**

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

300
47
39
906

DEC 20 1953

NOV 24 1948

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 Robert H Reed
Licensed Embalmer No. 3745
P. O. Address N.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.

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

2B
45
43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1002
Registrar's No. 4401

Registration District No. 1002

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

3. (a) PRINT FULL NAME Edgar R. Davies

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-29-48 (Date received local registrar) (b) Steraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cross out Broncho pneumonia on (add) record.

Due to acute barbituric acid intoxication

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence 10-28-48

(c) Where did injury occur? K.C. Jackson, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Robinson Clinic

While at work? no (Specify type of place) (e) Means of injury poison

23. Signature A. E. Upsher (M. D. or other)

Address 2800 main Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-36976