

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

40090

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

FILED DEC 29 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5061

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

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 1/2 hrs.  
(Specify whether)

In this community 19 YEARS  
years, months or days

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. 3023 E. 19 Terr. 5  
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WINSTON Samuel Davidson

3. (b) If veteran, name war No

3. (c) Social Security No. 500-03-8353

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10  
year 1948 hour 2 minute 7 A. M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. SARAH EVELYN DAVIDSON

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased: OCTOBER 23 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 9, 1948, to Dec. 10, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Osteogenic sarcoma of pelvis

Duration \_\_\_\_\_

8. AGE: Years 80 Months 1 Days 17  
If less than one day hr. \_\_\_\_\_ min.

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

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

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

Other conditions: 55 lb  
(Include pregnancy within 3 months of death)

10. Usual occupation RETIRED

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business 4 YEARS

Of autopsy See above

12. Name THOMAS DAVIDSON 9

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

14. Maiden name JANE ASHFORD

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

16. (a) Informant MRS. SARAH EVELYN DAVIDSON

(b) Address 3023 EAST 19TH STREET TERRACE

17. (a) BURIAL (b) Date thereof DEC-13-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILLS CEMETERY

18. (a) Signature of funeral director: M. Newman

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 12-13-48 (b) W. Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

Wm. W. Hart (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Manner of injury \_\_\_\_\_

23. Signature Wm W Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 12-10-48

**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 \_\_\_\_\_

*Doyle L. Daniel*, Registered Apprentice No. *278*,  
working under my personal supervision.

Signed *Edward M. Storey*

Licensed Embalmer No. *4452*

P. O. Address. *K.C., 4 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.**