S. No. 300
V. 10.48

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

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15824

BIRTH NO. ____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2077

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City Twp
c. LENGTH OF STAY (in this place): 30 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1411 E. 13th

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson 48
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Kansas City 3
d. STREET ADDRESS (If rural, give location): 1411 E. 13th 8

3. NAME OF DECEASED (Type or Print): a. (First) Henry b. (Middle) Lee c. (Last) Davis

4. DATE OF DEATH: (Month) May (Day) 10 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-15 1886
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months ~~4~~ Days ~~15~~ — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: John Davis
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Elizabeth Gravett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Elizabeth Davis ADDRESS: 1411 E. 13th.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) La Grippe 480X
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Ca Hydrocele & unilateral rupture

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/7/49, *to* May 10, 1949, *that I last saw the deceased alive on* May 10, 1949, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. V. Miller (Degree or title): M.D.
23b. ADDRESS: 1211 Paseo
23c. DATE SIGNED: 5/11/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 12, 1949
24c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Lawn
24d. LOCATION (City, town, or county) (State): Kansas City, Mo.

DATE REC'D BY LOCAL REG.: 5-12-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Fannie L. Meek ADDRESS: K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.