

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42234**
Registrar's No. **5461**

1953 JAN 5 1953
BIRTH NO. **84805** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) Lifetime		d. STREET ADDRESS (If rural, give location) 1305 Brooklyn	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2			
3. NAME OF DECEASED (Type or Print) a. (First) Marion		b. (Middle) Denise	
c. (Last) Davis (#1)		4. DATE OF DEATH (Month) (Day) (Year) 12 10 52	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 10-30-52 (a twin)
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Month Day Hours 1 14	IF UNDER 24 HRS. Hours Mins. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? America	
13a. FATHER'S NAME -		13b. MOTHER'S MAIDEN NAME Lelia Davis	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Lelia Davis, 1305 Brooklyn	
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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-9-52 , 19___, to 12-10-52 , 19___, that I last saw the deceased alive on 12-10-52 , 19___, and that death occurred at 1:25 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. Frank Elise MD		23b. ADDRESS 600 East 22nd Street	
23c. DATE SIGNED 12-11-52			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12/13/52	
24c. NAME OF CEMETERY OR CREMATORY Wepfer and Son		24d. LOCATION (City, town, or county) (State) Kansas City, Mo	
DATE REC'D BY LOCAL REG. 12-13-52		REGISTRAR'S SIGNATURE Eveline Smith	
25. FUNERAL DIRECTOR'S SIGNATURE E. Steinhilber		ADDRESS Bill 212 Vene	

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.