

FILED APR 4 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8169**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1091

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 OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 31 yrs	c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 1703 1/2 Agnes		STREET ADDRESS (If rural, give location) 1703 1/2 Agnes	

3. NAME OF DECEASED (Type or Print) a. (First) Luther b. (Middle) _____ c. (Last) Davis		4. DATE OF DEATH (Month) (Day) (Year) Mar 10, 1955	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 15, 1879
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Marshall, Texas
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Mary Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY 496-03-5618	17. INFORMANT'S SIGNATURE OR NAME Mary Davis ADDRESS 1793; Agnes
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Carcinoma of Prostate	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		177X	
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)	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 Jan. 29, 1955 to March 4, 1955, that I last saw the deceased alive on March 4, 1955, and that death occurred at 6:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE William H. Bryan M.D.	(Degree or title) D	23b. ADDRESS 2204 E. 18th St. K.C. Mo.	23c. DATE SIGNED 3-11-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Mar. 14, 1955	24c. NAME OF CEMETERY OR CREMATORY Lincoln	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 3-11-55	REGISTRAR'S SIGNATURE Neva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Bros. Funeral Home ADDRESS 18th Benton
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed: *Bruce P. Watkins*

Licensed Embalmer No... *452*

P. O. Address... *18th Ben*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.