

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

19363

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Ray Primary Registration District No. 1002  
City Kansas City (No. City Hospital #2)

File No. 2550  
Registered No. 2550  
St. 3 Ward

**2. FULL NAME**

Callie Davis  
(a) Residence. No. 2914 Summit St., 3 Ward.  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX  
Female

4. COLOR OR RACE  
col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
Henry Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR)  
Aug 19, 1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>39</u>	<u>9</u>	<u>13</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family's  
(c) Name of employer by the day

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
MO

10. NAME OF FATHER Sam Medlock

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
to Carolina

12. MAIDEN NAME OF MOTHER Abigail Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)  
MO

14. INFORMANT Mrs Anita Henderson  
(Address) 1025 Walker Ave. K.C. Mo

15. FILED 64, 19 30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2nd 1930

17. I HEREBY CERTIFY, That I attended deceased from 3/17 1930, to May 2 1930 that I last saw h. alive on May 2 1930 and that death occurred, on the date stated above, at 6-20 p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral spinal Meningeal  
(Non-malignant)

54E (duration) yrs. 5 mos. — ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
Don't know  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) [Signature] M. D.

6/4, 19 30 (Address) 1830 Union

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL West Lawn DATE OF BURIAL 6-6 1930

20. UNDERTAKER K.B. Emb &asket Co ADDRESS 700 State Ave K.C. Kansas

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

