

FEB 26 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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: Lake Side Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Nov 27 to Jan 3-1940
(Specify whether years, months or days) 23 years

3. (a) PRINT FULL NAME

Jack Davidge

3. (b) If veteran, name war No

3. (c) Social Security No. 481-CT-2320

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Dorothy Davidge

6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased March 17 1915

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>24</u>	<u>9</u>	<u>16</u>	hr. min.

9. Birthplace

(City, town, or county) Penn (State or foreign country)

10. Usual occupation

Clerk

11. Industry or business

Drug Store

FATHER

12. Name A.C. Davidge

13. Birthplace Penn (State or foreign country)

MOTHER

14. Maiden name Mary E. Mayer

15. Birthplace New Jersey (State or foreign country)

16. (a) Informant's own signature W. E. Davidge

(b) Address St. 6 - North Kansas City, Mo

17. (a) Burial (b) Date thereof 1-5-1940

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blount Hills

18. (a) Signature of funeral director Eads Bros Funeral Home

(b) Address 1416 Minnesota Bldg

19. (a) 1940 (b) M. M. Crowe

(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town North Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R. 7. D # 5
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3
year 1940 hour 4 minute 30 AM

21. I hereby certify that I attended the deceased from Sept 12-1939 to January 3, 1940

that I last saw him alive on January 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Toxic myocarditis Duration 30 days

Due to Metastatic sarcoma 1 year

Due to Primary - Left Scapula 57

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

Major findings: (by X Ray) sarcoma of lining of shoulder, spine

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph A. Rice (M.D. or other) DO

Address Shubert Bldg Date signed 1/3/40

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

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.

1 X1931

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

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, above space should be left blank.