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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 14 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24079

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2689

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 412 S Quincy (If not in hospital or institution, write street number or location) 5
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City, Mo. (If outside city or town limits write "RURAL")
(d) Street No.: 412 S Quincy (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: Elmer Davis 120
3. (b) If veteran, name war: None
3. (c) Social Security No.: none
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mrs. Hester Davis
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: Dec. 13, 1870 (Month) (Day) (Year)

8. AGE: Years 69 | Months 6 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Indiana (City, town, or county) (State or foreign country) 1
10. Usual occupation: Auditor 1
11. Industry or business: City of K.C.Mo. 1

FATHER
12. Name: John Davis
13. Birthplace: Ky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah
15. Birthplace: Indiana (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Hester Davis
(b) Address: 412 S Quincy, K.C.Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 5th-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: C.H.Blackman & Son.Inc.
(b) Address: 2825 Indep. Blvd. K.C.Mo.
19. (a) July 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1940 hour 2 minute 25 P.M.
21. I hereby certify that I attended the deceased from July 29, 19__, to July 31, 1940 that I last saw him alive on July 31 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of stomach — Duration
Due to: 45
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy: no.

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: 1

23. Signature: [illegible] (M. D. or other)
Address: 920 Linwood K.C. Date signed 7/4/40

(Licensed Embalmer's Statement on Reverse Side)

Dr. Mulvaney

Ph 5/15

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 R D Blackman

Licensed Embalmer No. 3639

P. O. Address K.C. Mo

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, above space should be left blank.