

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34283

Registrar's No. 3799

1002

NOV 17 1940
Registration District No. 99

Primary Registration District 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: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9-26-40-9-28-40
(Specify whether years, months or days) 17 months

8. (a) PRINT FULL NAME Margery Davis

3. (b) If veteran, name war WW 3. (c) Social Security No. No.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3 31 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 5 28 _____ hr. _____ min.

9. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

12. Name Clarence Davis

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Naomi Brown

16. Birthplace Missouri
(City, town, or county) (State or foreign country)

18. (a) Informant Record Clerk
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 10 / 1 / 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Waddins Bros.

(b) Address 1729 Lydia

19. (a) 10-1-40 (b) Mr. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limit, write "RURAL")
(d) Street No. 2453 Flora Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 28
year 40 hour 2 minute A.M.

21. I hereby certify that I attended the deceased from 9-26-, 1940 to 9-28-, 1940
that I last saw her alive on 9-28-, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to Whooping Cough

Due to _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

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

23. Signature J. O. Thompson (M.D. or other) _____
Address General Hospital # 2 Date signed 10-1-40

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

MOTHER FATHER

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

Isaac Jerome Manlove

Licensed Embalmer No.

3994

P. O. Address

1120 E. 23rd St.

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.