

FEB 18 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 457

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: K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 26 days  
 (Specify whether years, months or days)  
 In this community 39 Years

3. (a) PRINT FULL NAME Mae Nellie Davis3. (b) If veteran, name war No 3. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Mr. Charles J. Davis, Sr. 6. (c) Age of husband or wife if alive 50 years7. Birth date of deceased April 10 1901  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
39 9 20 hr. min.9. Birthplace Independence Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business -----

12. Name William O. Gilchrist13. Birthplace Illinois  
(City, town, or county) (State or foreign country)14. Maiden name Anna Lockard15. Birthplace Illinois  
(City, town, or county) (State or foreign country)16. (a) Informant Mr. Charles J. Davis, Sr.(b) Address 3703 East 35th Street17. (a) Burial (b) Date thereof Feb. 1, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park Cemetery18. (a) Signature of funeral director D. H. Newcomer's Sons(b) Address 1401 Brush Creek Blvd.19. (a) Jan 31, 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3703 East 35th St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? ----- years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30th  
year 1941 hour 2 minute 31 P. M.21. I hereby certify that I attended the deceased from 1-4-41, 1941, to 1-30-41, 1941;  
that I last saw her alive on 1-30-41, 1941;  
and that death occurred on the date and hour stated above.Immediate cause of death Acute Fibrino Purulent Generalized Peritonitis and Toxic myocarditis.

Due to -----

Due to -----

Other conditions -----  
(Include pregnancy within 3 months of death)Major findings:  
Of operations -----Of autopsy See above

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) (By Means of injury) Ⓢ23. Signature Darcy R. Shaw (M. D. or other) -----  
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE 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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Emile M. Calhoun*

Licensed Embalmer No. *3506*

P. O. Address *TC MO*

**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, fact should be so stated above.**

ABLE COPY

**MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **457**

**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**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits write "RURAL")  
 (d) Street No. **3703 E. 435th St.**  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.?..... years.

**3. (a) PRINT FULL NAME** **Nellie Mae Davis**

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

4. Sex **Fe** 5. Color or race **White** 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**39 Yrs.** .....

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. **Jan 31 1941** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Jan.** day **30th**  
 year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
 19..... to..... 19.....  
 that I last saw h..... alive on..... 19.....  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute fibrino purulent generalized peritonitis & toxic myocarditis**

Due to **Acute exacerbation of pelvic inflammatory disease caused by the removal of a pessary of three years standing.**

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

Major findings:  
 Of operations.....

Of autopsy **Above**

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 **Drury R. Thorn** (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

