

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED FEB 14 1945

Registration District No. **189**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **JACKSON**

(b) City or town **KAIVSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4534 FOREST AVENUE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **35 YEARS** /
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** **48**

(c) City or town **KAIVSAS CITY** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **4534 FOREST AVENUE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
0
If yes, name country _____

3. (a) PRINT FULL NAME **GILBERT WELCH DAVIS**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NOISE**

4. Sex **MALED** 5. Color or race **WHITE**

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

6. (b) Name of husband or wife **EFFIE**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **OCTOBER 5 1875**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **31** ST
year **1945** hour **5** minute **05 A.M.**

21. I hereby certify that I attended the deceased from **Nov. 24**
1945 to **Jan 31 1945**
that I last saw him alive on **Jan 7 1945**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	69	3	23	_____ hr. _____ min.

Immediate cause of death **Congestive Heart Failure** **1 1/2 yrs**
Hypertension **10 yrs**
mitral stenosis **7 yrs**

Due to _____

Due to _____

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

10. Usual occupation **TEACHER INDUSTRIAL ARTS**

11. Industry or business **KAIVSAS CITY PUBLIC SCHOOLS**

12. Name **ALBERT DAVID**

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

14. Maiden name **MARY WELCH**

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

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

Major findings: Of operations **926**

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Effie Davis**

(b) Address **4534 Forest**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-1-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah**

18. (a) Signature of funeral director **D. E. Brown**

(b) Address **1401 BRUSH CREEK BLVD.**

19. (a) **2-1-45** (Date received local registrar) (b) **D. E. Brown** (Registrar's signature)

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)

23. Signature **D. E. Brown** (M. D. or other) **1-31-45**
Address **1500 N. 13th St** Date signed **1-31-45**

1500 Professional Bldg.
2-5:30

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 *E. Oscar Thorpe*.....

Licensed Embalmer No. 1767.....

P. O. Address Kansas City.....

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.