No. 2
12-45
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21707

Registration District No. 236 Primary Registration District No. 5819 Registrar's No. 33

1. PLACE OF DEATH:
(a) County Morgan Osage Twsp.
(b) City or town Rural Gravios Mills MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 2 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City MO 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5114 Lydia Ave 6
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALBERT JAMES DAVIES
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida Mae Aubele
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased March (Month) 19th (Day) 1917 (Year)

8. AGE: Years 30 Months 3 Days 9 If less than one day hr. min.

9. Birthplace Jackson Co (City, town, or county) MO (State or foreign country)
10. Usual occupation Photographer
11. Industry or business

FATHER
12. Name Albert J. Davies
13. Birthplace Canada (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Esther Huntington
15. Birthplace Neb. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ida M. Davies
(b) Address 5114 Lydia Kansas City MO
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-29-47 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn, Kansas City
18. (a) Signature of funeral director J. F. Kidwell
(b) Address Versailles MO
19. (a) 6/29/47 (Date received local registrar) (b) J. L. Wash (Registrar's signature) 714

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th year 1947 hour 3 minute 30 P. 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.

	Duration
Immediate cause of death Asphyxiation	
Due to Sy. Drowning	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Birch L. Medicus (M. D. or other) Morgan City Coroner
Address Versailles Mo. Date signed 6-28-47.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 6-47-842
Date Filed 7-8-42

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 H. T. Cadwell

Licensed Embalmer No. 1596

P. O. Address Versailles Missouri

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.

S. No. 2B
3M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21707

Registration District No. 236 Primary Registration District No. 5819 Registrar's No. 33

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Morgan

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

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

(d) Length of stay: In hospital or institution (Specify whether
In this community 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.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Albert J. Davies

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 19 (Day) 1917 (Year)

8. AGE: Years 30 Months 3 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 28 year 194 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 Asphyxiation

Due to By Drowning

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 18 3
Of autopsy 36

Duration

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) Accident

(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 Birch L. Medlin Morgan County Coroner (M. D. or other)

Address Versailles Mo. Date signed 7-19-47.

S-21707