

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33483**
4205

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>2002</u> | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> | | | |
| b. CITY OR TOWN <u>KANSAS CITY</u> | | c. LENGTH OF STAY (In this place) <u>unk.</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | d. STREET ADDRESS (If rural, give location) <u>Brookside Hotel 34th & Brookside Blvd.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LUKES HOSPITAL</u> | | | | d. STREET ADDRESS (If rural, give location) <u>Brookside Hotel 34th & Brookside Blvd.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ALBERT W</u> b. (Middle) _____ c. (Last) <u>DAVIS</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>OCT-4-1950</u> | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>June 1 1863</u> | |
| 9. AGE (In years last birthday) <u>87</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician RETIRED STS. GENERAL PRACTITIONER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>Salem, Indiana</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>John W. Davis</u> | | 13b. MOTHER'S MAIDEN NAME <u>Deborah D. Denny</u> | | 14. NAME OF HUSBAND OR WIFE <u>MOLLIE E. DAVIS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mollie E. Davis Brookside Hotel R.C.Mo.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastrointestinal hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>duodenal ulcer</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture rt. femur.</u> | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City Jackson Mo</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8-26-50</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>fell in his room.</u> | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>F.C. Coleman</u> (Degree or title) <u>M.D. Pathologist</u> | | | | 23b. ADDRESS <u>04923 Bell St. K.C. Mo.</u> | | 23c. DATE SIGNED <u>OCT 4, 1950</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Oct. 6, 1950</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Topeka Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Topeka Kansas</u> | |
| DATE REC'D BY LOCAL REG. <u>10-5-50</u> | | REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P.W. Newcomer's Sons 1231 BRUSH CREEK BLVD. KANSAS CITY, MO.</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

6565 of
James
A. [unclear]

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Charles A. Strickney

Signed.....

Student Embalmer

Licensed Embalmer No. 4560

P. O. Address KC, 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.