

FILED FEB 7 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44486

BIRTH NO. 89720 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1008 Registrar's No. 5831

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

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 (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (to this place) <u>life</u>		d. STREET ADDRESS (If rural, give location) <u>1118 East 16th Street 3268</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #2</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Louise</u>	b. (Middle)	c. (Last) <u>Davis</u>	<u>12</u>	<u>20</u>	<u>52</u>

5. SEX <u>3</u> <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>12-19-1952</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		

13a. FATHER'S NAME <u>John Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Lida Lakes</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lida Lakes Davis, 1118 E. 16th.</u>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital atelectasis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity.</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>76 25</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-19-52, 19 , to 12-20-52, 19 , that I last saw the deceased alive on 12-20-52, 19 , and that death occurred at 2:00 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>E. Frank Ellis MD</u>	(Degree or title)	23b. ADDRESS <u>600 East 22nd Street</u>	23c. DATE SIGNED <u>12-22-52</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE <u>1-18-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverside</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, MO</u>
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DATE REC'D BY LOCAL REG. <u>12-31-52</u>	REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm A. Schmeyer, D.C. Mo.</u>	ADDRESS
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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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Wm. A. Johnson* _____

Licensed Embalmer No. *3089* _____

P. O. Address *ITC MD* _____

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.