

FILED AUG 27 1954

STANDARD CERTIFICATE OF DEATH

 State File No. **27184**
3788

 BIRTH NO. 52653-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Jackson		a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		b. COUNTY Jackson	
c. LENGTH OF STAY (in this place) 5 hours		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital		d. STREET ADDRESS (If rural, give location) 203 1/2 College	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Infant James	b. (Middle) -----	c. (Last) Davis	(Month) August	(Day) 2	(Year) 1954
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH August 2, 1951		9. AGE (In years last birthday) 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas City, Missouri	
12. CITIZEN OF WHAT COUNTRY? American					

13a. FATHER'S NAME Willie James Davis	13b. MOTHER'S MAIDEN NAME Jacqueline Harmon	14. NAME OF HUSBAND OR WIFE None
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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) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mr. Willie James Davis, father	ADDRESS 203 1/2 College
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity		
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

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) (Min.)	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 August 2, 1954, to August 2, 1954, that I last saw the deceased alive on August 2, 1954, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE Samuel U. Rodgers (Degree or title) <i>Samuel U. Rodgers M.D.</i>	23b. ADDRESS 2462 A Brooklyn	23c. DATE SIGNED 8-3-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 8-4-54	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Kansas
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DATE REC'D BY LOCAL REG. 8-4-54	REGISTRAR'S SIGNATURE <i>Sheraldine Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE Nathan W. Thatcher	ADDRESS Kansas City Ks
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Clifford Woods

Signed.....

Student Embalmer

Licensed Embalmer No. 3106

P. O. Address 1520 N. 5th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.