

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27185

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3221

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give town OR <b>KANSAS CITY, MO.</b> )	c. LENGTH OF STAY (in this place) <b>2 Mo.</b>	c. CITY OR TOWN <b>KANSAS CITY</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>GENERAL HOSPITAL NO. ONE</b>		f. STREET ADDRESS (If rural, give location) <b>4440 MAIN</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>H</b> c. (Last) <b>DAVIS</b>	4. DATE OF DEATH (Month) <b>7-9</b> (Day) <b>554</b> (Year)
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>July 21-1922</b>	9. AGE (In years last birthday) <b>31</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TELEGRAPH OPER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>MT AYR IOWA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FLOYD DAVIS</b>	13b. MOTHER'S MAIDEN NAME <b>FLORENCE SHEIL</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>478-22-4926</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Florence Davis Chittick</b> ADDRESS <b>Mo</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Severe hemorrhagic diathesis</b>	INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <b>(Shock) Clinical</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <b>Heat Stroke</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>9.31g 46</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>123</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7-4, 1954, to 7-9, 1954, that I last saw the deceased alive on 7-9, 1954 and that death occurred at 1:55p m., from the causes and on the date stated above.

23a. SIGNATURE <b>B.I. Burns MD</b> (Degree or title)	23b. ADDRESS <b>24 &amp; Cherry</b>	23c. DATE SIGNED <b>7-10-54</b>
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24a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>July 12-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT AYR IOWA</b>	24d. LOCATION (City, town, or county) (State) <b>MT AYR IOWA</b>
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DATE REC'D BY LOCAL REG. <b>7-10-54</b>	REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John P. Sheil R. C. WA</b> ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 16 1954

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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 ..... Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John P. Sheil*.....

Licensed Embalmer No. *362*

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.