

STANDARD CERTIFICATE OF DEATH

1186

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1009 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) Aprox.		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 709 Washington		ii. STREET ADDRESS (If rural, give location) 709 Washington .31/8	

3. NAME OF DECEASED (Type or Print) a. (First) Roy	b. (Middle)	c. (Last) Davis	4. DATE OF DEATH (Month) (Day) (Year) 3-12-55
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Aprox. 72	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (City and State or Foreign Country) unknown	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 491-20-770A	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary R. Pratt, 709 Washington	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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death unknown		INTERVAL BETWEEN ONSET AND DEATH  795
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  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 No Relatives	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) Natural	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 <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

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 \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. OWENS (Degree or title)	23b. ADDRESS 1034 Realto Bldg.	23c. DATE SIGNED 3-15-55
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24a. BURNING CREMATION (Specify) Removal	24b. DATE 3-15-55	24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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DATE REC'D BY LOCAL REG. 3-16-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE H. Tegument Law	ADDRESS
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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *J. Roy Moore*.....

Licensed Embalmer No. *477*.....

P. O. Address *K.C.*.....

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.