

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12167

Health,  
Welfare  
Public  
Service

STATE FILE NUMBER

1000

Registrar's No.

497

Registration District No. 42 Primary Registration District No.

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Agency</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hosp.</b>		Length of stay in 1b <b>4 days</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>HENRY M. DAVIS</b> First Middle Last			4. DATE OF DEATH <b>May 2, 1957</b> Month Day Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1890</b>
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Agency, Missouri</b>
13. FATHER'S NAME <b>Bart Davis</b>		14. MOTHER'S MAIDEN NAME <b>Susan Moore</b>	
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>487-14-6719</b>	17. INFORMANT <b>Mrs. H. M. Davis, Agency, Mo.</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral embolism</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>myocardial infarction</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <b>4201</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days 4 days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>April 29-57</b> to <b>May 2-57</b> and last saw her alive on <b>May 2-57</b> . Death occurred at <b>8:15 P. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>St. Melaney M.D.</b>		22b. ADDRESS <b>214 Kirkpatrick St. Joseph, Mo</b>	22c. DATE SIGNED <b>May 5-2-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/4/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Agency, Missouri</b>
24. FUNERAL DIRECTOR <b>Heaton-Bowman, St. Joseph, Missouri</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>May 6, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

securing the medical certificate in the specific manner

4850

1001 31 1957

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 *James B. Hawkins*  
Licensed Embalmer No. 453

P. O. Address 319 So 10th St

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.