

Health, Welfare, Public Service

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28409 STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 381

300
-57

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, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		c. CITY OR TOWN <u>INDEPENDENCE 700</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>INDEPENDENCE SAN. HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>9525 EAST 15TH STREET</u>	
Length of stay in 1b <u>26 YEARS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>E.</u> Last <u>DAVIS</u>	4. DATE OF DEATH Month <u>AUGUST</u> Day <u>25</u> Year <u>1957</u>
---	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 20. 1886</u>	9. AGE (In years last birthday) <u>70</u>	10. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS.
--------------------	-------------------------------	---	--	---	--	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE-PRESIDENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	11. BIRTHPLACE (City and state or country) <u>WEBB CITY, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	--	---

13a. FATHER'S NAME <u>BERT DAVIS</u>	13b. MOTHER'S MAIDEN NAME <u>MARILDA MARTIN</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. OLIVE DAVIS</u>
---	--	--

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>512-07-9316</u>	17. INFORMANT <u>MRS. OLIVE DAVIS</u> Address <u>9525 EAST 15TH STREET INDEPENDENCE MISSOURI</u>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		<u>unknown</u>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>331X</u>
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 <u>8-25-57</u> to <u>8-25-57</u> and last saw her alive on <u>8-25-57</u> Death occurred at <u>7:20 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. Anderson</u> (Degree or title)	22b. ADDRESS <u>171 1/2 W Lexington Indpls Mo</u>	22c. DATE SIGNED <u>8-26-57</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG-28-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
--	---------------------------------	--	--

24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>	ADDRESS <u>1331-DRUSH CREEK KANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>8-28-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	--	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

SEP 14 1950

SEP 18 1957

SEP 3 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 *Chester K Brown*

Licensed Embalmer No. *493*

P. O. Address *Ke...*

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.