

Health, Welfare
Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31794
STATE FILE NUMBER
4079

FILED SEP 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4079

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, give TOWNSHIP only) OR TOWNSHIP Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6705 E. 18th St.		d. STREET ADDRESS (If outside, give location) 6705 E. 18th St.	

3. NAME OF DECEASED (Type or print) First BERTHA Middle MAE Last DAVIDSON			4. DATE OF DEATH Month 8 Day 30 Year 57			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1885	9. AGE (In years last birthday) 71	10. FUNDER 1 YEAR Months _____ Days _____	11. 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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Albert B. Brizendine	13b. MOTHER'S MAIDEN NAME Alice P. Church	14. NAME OF HUSBAND OR WIFE Geo. Davidson
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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. no	17. INFORMANT Leroy Davidson 808 E. 27th St
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH several months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) unknown		
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from July 30-57 to Aug 30-57 and last saw ^{her} him alive on Aug 30-57 Death occurred at 7:12 P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE John W. Cashman, M.D. (Degree or title)	22b. ADDRESS 535 Angell Bldg, KC 6, Mo	22c. DATE SIGNED 8/31/57
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	9/2/57	Brookings Cemetery	Jackson Co. Mo.

24. FUNERAL DIRECTOR Sheil Funeral Home	ADDRESS K.C. Mo.	25. DATE RECD. BY LOCAL REG. 9-1-57	26. REGISTRAR'S SIGNATURE Irene Marshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John W. Cashman

All diseases in Part I must be causally related.

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 *Richard E. Canoll*

Licensed Embalmer No. *4829*

P. O. Address *H. C. No.*

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.