

Health,  
& Welfare  
Public  
Service

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35762  
STATE FILE NUMBER  
149 Primary Registration District No. 1002 Registrar's No. 5068

S. 300 D  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>JOHNSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MISSION</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LUKE'S HOSPITAL</b>		Length of stay in 1b <b>1 WEEK</b>	d. STREET ADDRESS (If outside, give location) <b>6005 GRANADA</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>R.</b> Last <b>DAVIS</b>			4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>28</b> Year <b>1957</b>		
5. SEX <b>FEMALE</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>OCTOBER 11, 1884</b>	9. AGE (In years last birthday) <b>73</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>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <b>TUKA, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>MARTIN LENZ</b>		13b. MOTHER'S MAIDEN NAME <b>ELLA M. JOHNSON</b>		14. NAME OF HUSBAND OR WIFE <b>LEONARD W. DAVIS</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>NONE</b>	17. INFORMANT Address <b>LEONARD W. DAVIS 6005 GRANADA MISSION, KANSAS</b>		
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>Bronchial pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of bladder &amp; extension to bone and adjacent structures.</b>					<b>20 Mos.</b>
DUE TO (c) <b>Pyonephrosis, left</b>					<b>2 Wks.</b>
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 checked="" type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY 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 <b>2-22-56</b> to <b>10-28-57</b> and last saw <sup>her</sup> alive on <b>10-28-57</b> Death occurred at <b>9:50</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Raymond W. Hochstetler</b> (Degree title) <b>M.D.</b>			22b. ADDRESS <b>200 Plover Drive Bldg Keho</b>		22c. DATE SIGNED <b>10-29-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT 31 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>10-31-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

Raymond W. Stock of use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Bernard L. Horne*

Licensed Embalmer No. *4250*  
P. O. Address *N.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.