

Health,
& Welfare
Public
Service

FILED NOV 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39546

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 170

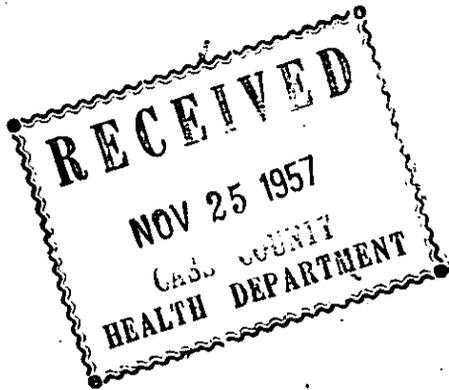
S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Cass</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Harrisonville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>204 E. Washington</u>		Length of stay in 1b <u>54 yr</u>	d. STREET ADDRESS (If outside, give location) <u>204 E. Washington</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ELIZABETH DAVIS</u>			4. DATE OF DEATH Month Day Year <u>Nov 18 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 5 1879</u>		9. AGE (In years last birthday) <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Parkville Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Daniel Powell</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Emeline Vest</u>		14. NAME OF HUSBAND OR WIFE <u>C H 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>NONE</u>	17. INFORMANT Address <u>Elmer D. Lemke</u> <u>Horseshoe</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>EMACIATION & MALNUTRITION</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>CHRONIC DIARRHEA</u>					<u>8 YRS</u>
DUE TO (c) <u>UNDETERMINED ETIOLOGY</u>					<u>8 YRS</u>
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.)		
20c. TIME OF INJURY Hour Month, Day, Year 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>March 18 1957</u> to <u>Nov. 13 1957</u> and last saw her alive on <u>Nov. 13 1957</u> Death occurred <u>11:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. Wood, M.D.</u>			22b. ADDRESS <u>Harrisonville Mo.</u>		22c. DATE SIGNED <u>11-20-57</u>
23a. BURIAL CREMATION, REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial Nov 20-1957</u>		<u>Oakland Cemetery</u>		<u>Harrisonville Mo</u>	
23b. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
<u>Pennsylvania Harrisonville Mo</u>		<u>Nov 20 1957</u>		<u>Nora Barman</u>	

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.

(Licensed Embalmer's Statement on Reverse Side)



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 R. Phillips*

Licensed Embalmer No. *464*

P. O. Address *Hansonville*

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.