

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 5 - 1957

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

S. 300  
v. 1-57

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 TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in 1b 4 1/2 YEARS	d. STREET ADDRESS (If outside, give location) 406 No. Bellaire		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS JEFFERSON DAVIS			4. DATE OF DEATH Month Day Year Nov 17, 1957		
5. SEX Male	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 July 27, 1877	9. AGE (In years last birthday) 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car repairer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Atchison, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Thomas C. Davis		13b. MOTHER'S MAIDEN NAME: FLORENCE Mary, Hayes		14. NAME OF HUSBAND OR WIFE Edith Mae DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes SAW		16. SOCIAL SECURITY NO. 510-05-3812A	17. INFORMANT VA Hospital Official Records, K.C., Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, R.L.L.  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Vesicular emphysema, advanced.					INTERVAL BETWEEN ONSET AND DEATH  5271
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. attended the deceased from Death occurred at 7:10 AM			Aug. 14, 1957 to Nov. 17, 1957		
22a. SIGNATURE J. A. Turner		(Degree or title) M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	
22c. DATE SIGNED 11-17-57					
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov. 19, 1957		Memorial Park	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS		ADDRESS 1331 1/2 Bush Creek K. C. Mo		25. DATE RECD. BY LOCAL REG. 11-19-57	
				26. REGISTRAR'S SIGNATURE Irene Minshall	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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**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 *Vern Lawler* .....

Licensed Embalmer No. *4915*  
P. O. Address *47 E 37* .....

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.