

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005453

STATE FILE NUMBER

617

FILED MAR 3 - 1958

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

Health
Welfare
Public
Service

300
-57

Robert M. Myers
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in relation to cause of death.

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>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</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>109 E. 40th St</u>		Length of stay in lb <u>15 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>109 E. 40th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roy E. DAVIS</u>			4. DATE OF DEATH Month Day Year <u>2 5 58</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>5/29/1898</u>
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Res. Bank</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Charles Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Estelle Thomas</u>	
14. NAME OF HUSBAND OR WIFE <u>Winifred 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>no</u>	17. INFORMANT Address <u>Mrs Winifred Davis 109 E. 40th St.</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>metastatic Ca</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Ca Brain - Surgery</u> DUE TO (c) <u>12 yrs (?) ago</u>			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>yr</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 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. I attended the deceased from <u>19 Jan</u> to <u>5 Feb 58</u> and last saw ^{her} him alive on <u>5 Feb 58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert M. Myers M.D.</u>		22b. ADDRESS <u>1025 Shatto Bldg</u>	22c. DATE SIGNED <u>5 Feb 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/7/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRACELAND</u>	23d. LOCATION (City, town, or county) (State) <u>Weston MO.</u>
24. FUNERAL DIRECTOR <u>Vaughn Funeral Home - Weston</u>		25. DATE RECD. BY LOCAL REG. <u>no</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>



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 *Walter R. Van... ..*

Licensed Embalmer No. *4023*.....
P. O. Address *Weston, 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.