

Health,
Welfare
Public
Service

300
1-57

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

78-009890
STATE FILE NUMBER
1080

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1080

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 hospital 43 YEARS		d. STREET ADDRESS (If outside, give location) 3005 Main, K.C., Mo		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Willmore CLARK Davis				4. DATE OF DEATH Month Day Year 2nd 26th 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-28-95		9. AGE (In years last birthday) 62 yrs	10. FUNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, or if retired) Night Clerk			10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT & SIDING		11. BIRTHPLACE (City and state or country) Ft. Smith, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Samuel Davis			13b. MOTHER'S MAIDEN NAME Addie Glasscock			14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 195 05 9106		17. INFORMANT Address V.A. Hospital 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) <u>Asphyxiation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>Lobar pneumonia, bilateral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH 490 X		
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.) 7						
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 February 25, 1958 to February 26, 1958 and observed the death occurred at 10:35 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE COZZARELLI M.D.				22b. ADDRESS V.A. Hospital, Kansas City, Mo		22c. DATE SIGNED 2-27-58			
23a. BURIAL - CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
BURIAL		FEB. 28, 1958	MEMORIAL PARK		KANSAS CITY, MISSOURI				
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS - KANSAS CITY				25. DATE RECD. BY LOCAL REG. 2-28-58		26. REGISTRAR'S SIGNATURE new munnell			



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 *Chester K Brewer*

Licensed Embalmer No. *4931*
P. O. Address *KE 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.