

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001264

STATE FILE NUMBER

FILED FEB 5 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 331

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City Mo</i>		c. CITY OR TOWN <i>Kansas City</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>10617 Indian Creek Rd</i>		d. STREET ADDRESS (If outside, give location) <i>10617 Indian Creek Rd</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs Edna Jane Davis</i>		4. DATE OF DEATH Month Day Year <i>1-17-1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (City and state or country) <i>Indian Territory, Oklahoma U S A</i>
13a. FATHER'S NAME <i>L B Newkirk</i>		13b. MOTHER'S MAIDEN NAME <i>Nancy Jane Copeland</i>	13c. NAME OF HUSBAND OR WIFE <i>Robert Thompson Davis</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no none</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>William Davis 10617 Indian Creek Rd Kca</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH
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 <i>7-21-58</i> to <i>1-17-59</i> and last saw her alive on <i>1-17-59</i> Death occurred at <i>5:25 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Raymond J. Caffrey, M.D.</i>		22b. ADDRESS <i>Grandview, Mo.</i>	
22c. DATE SIGNED <i>1-18-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-19-59</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt Moriah</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo</i>	
24. FUNERAL DIRECTOR ADDRESS <i>France-Warnall Funeral Home</i>		25. DATE RECD. BY LOCAL REG. <i>1-19-59</i>	
26. REGISTRAR'S SIGNATURE <i>neva minshall</i>			

Raymond J. Caffrey
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Forrest D. Caldwell*

Licensed Embalmer No. *4714*
P. O. Address *KC. 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.