Health, Welfare Public Service

300 -57 3

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-004554
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 190

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) D.O.A. Mo. Methodist Hospital — Length of stay in 1b 45 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 6824 Marie St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Edwin Middle Loyd Last Davis
4. DATE OF DEATH Month Feb. Day 17, Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH June 20, 1890
9. AGE (In years last birthday) 68 — 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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Meat Packing
11. BIRTHPLACE (City and state or country) Oakland Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Lillian Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO. 488-14-1770
17. INFORMANT Lillian Davis Address 6824 Marie St. St. Joseph Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) coronary artery disease — years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 2/12/59, to 2/12/59 and last saw her/him alive on 2/12/59
Death occurred at 3:30 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald J. Stallard (Degree or title) MD
22b. ADDRESS 902 Edmond
22c. DATE SIGNED 2/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Feb. 20, 1959
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
23d. LOCATION (City, town, or county) St. Joseph, Mo. (State)

24. FUNERAL DIRECTOR Earl A. Clark ADDRESS Clark Funeral Home St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Feb. 19, 1959
26. REGISTRAR'S SIGNATURE Geo. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Donald J. Stallard

MAR 3 1959

## 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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 4238

P. O. Address .....

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.