Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004555
STATE FILE NUMBER

FILED MAR 2 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 193

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1517 Angelique — Length of stay in Ib 42 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph 0117 c — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1517 Angelique St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Len Middle: Last: Davis
4. DATE OF DEATH Month: Feb. Day: 17 Year: 1959
5. SEX Male 2
6. COLOR OR RACE Negro
7. MARRIED [X] 1 NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Mar. 15-1889
9. AGE (In years last birthday) 69 — 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 Railroad Co.
11. BIRTHPLACE (City and state or country) Pine Bluff, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Not Known
13b. MOTHER'S MAIDEN NAME Mariah Williams
14. NAME OF HUSBAND OR WIFE Bessie Evelyn Ruth Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Bessie E. R. Davis — Address City 1517 Angelique

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) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
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] 2

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 unattended, to and last saw him alive on
Death occurred at 4:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Assistant City Health Officer 5 — 22b. ADDRESS 802 Faraon, St Joseph — 22c. DATE SIGNED 2-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Feb. 20-'59
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery
23d. LOCATION (City, town, or county) St. Joseph, (State) Mo.

24. FUNERAL DIRECTOR Wm. H. Alexander, ADDRESS St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Feb. 19, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Gardell

(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. L. H. Pifer

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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph,

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.