THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011928
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 58

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Fitzgibbon Hosp. — Length of stay in Hospital 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN Marshall c972 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 552 W North — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First JAMES Middle ROBERT Last DAVIS

4. DATE OF DEATH Month April Day 1 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH Nov. 3, 1881

9. AGE (In years last birthday) 77

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) Rail road employee

10b. KIND OF BUSINESS OR INDUSTRY Mo Pacific

11. BIRTHPLACE (City and state or country) Nelson, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hiram Davis

14. MOTHER'S MAIDEN NAME Mary Kaylor Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. No

17. INFORMANT Mrs. Mary E. Streeter Address Kansas City 4145 Forest

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
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

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 3-28-59, to 4-1-59 and last saw him alive on April 1 59
Death occurred at 3:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James A Reed (Degree or title) MD

22b. ADDRESS Marshall, Missouri

22c. DATE SIGNED 4-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 4-4-1959

23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Garden

23d. LOCATION (City, town, or county) (State) Marshall, Missouri

24. FUNERAL DIRECTOR Jack Reser **ADDRESS** Marshall

25. DATE RECD. BY LOCAL REG. 4-4-59

26. REGISTRAR'S SIGNATURE Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MAY 15 1959

MAY 20 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Jack W. Reser

Licensed Embalmer No. 46

P. O. Address Marsh

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.