

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS AUG 21 1959**

**59-029035**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3865 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>2 1/2 YRS.</u>	c. CITY OR TOWN <u>BELTON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If in hospital, give location) HOSPITAL OR INSTITUTION <u>708 GARFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>604 EAST 4TH ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>----</u> Last <u>DAVIS</u>	4. DATE OF DEATH Month <u>AUG</u> Day <u>7</u> Year <u>1959</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>EPHRAM DOBBS</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN A. DAVIS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>489-30-1974</u>	17. INFORMANT Address <u>PEARL LOGAN, BELTON, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Arteriosclerosis</u>	<u>8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis</u>	<u>8 yrs</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour <u>-</u> s.m. <u>-</u> p.m. <u>-</u>	Month, Day, Year <u>-</u>
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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
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21. I attended the deceased from 4-1-59 to 8-7-59 and last saw her/him alive on 8-7-59.  
 Death occurred at 11:00 A on the date stated above, and to the best of my knowledge, from the cause stated.

22. SIGNATURE (Degree or title) <u>Frank Paul Lawrencean MD</u>	22b. ADDRESS <u>428 S. White Ave</u>	22c. DATE SIGNED <u>8-7-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEMETERY</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. H. BLACKMAN &amp; SON INC. K.C. Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>8-10-59</u>
	26. REGISTRAR'S SIGNATURE <u>Neal Marshall</u>	

DOCUMENT

BY AFFIDAVIT OF  
 Frank Paul Lawrencean  
 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W.C. Ruess

Licensed Embalmer No. 487

P. O. Address R.C. Ma.

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