

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039275**

**FILED VS NOV 18 1959 59**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **172**

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>CASS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>CASS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Peculiar Twp.</b>		Length of stay in 1b <b>3 yrs</b>	c. CITY OR TOWN <b>DREXEL</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pleasant View Rest Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RURAL ROUTE</b>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>MELVIN</b> Last <b>DAVIDSON</b>			4. DATE OF DEATH Month <b>NOV</b> Day <b>9</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-1886</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	11. BIRTHPLACE (City and state or country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>JAMES B. DAVIDSON</b>	13b. MOTHER'S MAIDEN NAME <b>MARGARET (UNKNOWN)</b>	14. NAME OF HUSBAND OR WIFE <b>ESTELLA DAVIDSON</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>LAWRENCE DAVIDSON Drexel, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IRONIC HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>
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) <b>OSTEOARTHRITIS Scleros</b>		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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 **Oct 1957** to **Nov 9 1959** and last saw <sup>him</sup> alive on **Nov 8 1959**.  
 Death occurred at **Nov. 9 1959** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. W. Moody MD</b>	(Degree or title)	22b. ADDRESS <b>HARRISONVILLE Mo.</b>	22c. DATE SIGNED <b>11-10-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-11-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHARON Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Drexel, Missouri</b>
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24. FUNERAL DIRECTOR <b>Atkinson-Dickey Archie, Missouri</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov 11-1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Gray Sebrer</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Robert W. Atkinson

Licensed Embalmer No. 4902

P. O. Address Hermand...

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.