

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 26 1960

-60-026802

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3583

NDED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 35 Yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6039 E 13th St			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6039 E 13th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First HATTIE Middle FLORENCE Last DAVIS				4. DATE OF DEATH Month July Day 7 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/7/1891	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Hollister Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John Oliver			13b. MOTHER'S MAIDEN NAME Davie Biles			14. NAME OF HUSBAND OR WIFE Arthur Davis (Dec)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 495-05-0644		17. INFORMANT Roland O Stafford 6039 E 13th St K C Mo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and acidosis								INTERVAL BETWEEN ONSET AND DEATH 24 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Vomiting								5 days	
DUE TO (c) Hypertensive cardiovascular disease								unknown	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year									
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	
21. I attended the deceased from 7-5-60 to 7-7-60 and last saw her ^{her} alive on 7-7-60 Death occurred at 7:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Richard W. Keown M.D.				22b. ADDRESS 1500 Professional Bldg K.C., Mo			22c. DATE SIGNED 7-9-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 9 1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri				
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo				25. DATE RECD. BY LOCAL REG. 7-11-60		26. REGISTRAR'S SIGNATURE Neva Minshall			

DOCUMENT

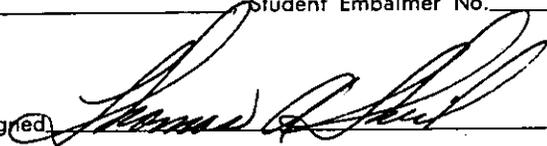
Richard W. Keown M.D. MEDICAL CERTIFICATION

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
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4934
P. O. Address F.P.M.

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.