

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-038329**

**FILED VS OCT 31 1960**

**5326**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5326

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1441 Independence Ave.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1441 Independence Ave</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>HELEN</u> Middle <u>W.</u> Last <u>DAVIS</u>			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>17</u> Year <u>1960</u>		
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b>	<b>9. AGE (last birthday)</b> <u>94</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Domestic</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Sherman, Texas</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>
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<b>13a. FATHER'S NAME</b> <u>—</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>—</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Daniel B. Davis</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT</b> Address <u>Weldon Davis, 4527 Antioch Road</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 years</u> <u>10 years</u>
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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<b>21. I attended the deceased from</b> <u>2-26-60</u> to <u>10-17-60</u> and last saw her/him alive on <u>10-12-60</u> Death occurred at <u>12 noon</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22. SIGNATURE</b> (Degree or title) <u>Frank Paul Lawrence M.D.</u>	<b>22b. ADDRESS</b> <u>428 S. White Ave</u>	<b>22c. DATE SIGNED</b> <u>10-17-60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>	<b>23b. DATE</b> <u>Oct. 18, 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>—</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Ada Oklahoma</u>
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<b>24. FUNERAL DIRECTOR</b> <u>832 Armour Press Road</u> <u>D.W. Newcomer's Sons, N.K.C. Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-18-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>H. S. Dwyer</u>
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DOCUMENT

BY AFFIDAVIT OF Frank Paul Lawrence M.D.

**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 *Chester K Brown*

Licensed Embalmer No. 49

P. O. Address KE 12

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.