

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18866

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2716

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>4 mos</b>	c. CITY OR TOWN <b>Kansas City</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>913 Forest</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS <b>913 Forest</b>		31580	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Leroy</b> b. (Middle) <b>Dean</b> c. (Last) <b>Scheets Davis</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 16 1954</b>	
5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Feb. 7, 1954</b>
9. AGE (In years last birthday) <b>4</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b>	IF UNDER 4 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Ira T. Davis (Step)</b>	13b. MOTHER'S MAIDEN NAME <b>Maxine Hammett</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Maxine Davis R. K.C. Mo.</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congenital cystic kidney</b>		
ANTECEDENT CAUSES		DUE TO (b) _____	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Natural</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **11:48A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title) <b>3</b>	23b. ADDRESS <b>1034 Rio Vista Plaza</b>	23c. DATE SIGNED <b>6-16-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-16-54</b>	24c. NAME OF CEMETERY OR CREMATORY _____
24d. LOCATION (City, town, or county) (State) <b>Paola, Kansas</b>		

DATE REC'D BY LOCAL REG. <b>6-17-54</b>	REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mrs. C. L. Forster Funeral Home K.C. Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

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

Student.....  
Signature of Student Embalmer

Signed.....  
*Joe B. Yoder*

Licensed Embalmer No. *447*

P. O. Address.....  
*H.C.M.*

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.