

FILED JAN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41783

STATE FILE NUMBER

 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5452

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>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>4109 Paseo</u>		Length of stay in lb <u>2 yrs</u>		d. STREET ADDRESS <u>4109 Paseo</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Dr. <u>First Middle Last</u> <u>MARION PRICHARD vonDavid</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1887</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (City and state or country) <u>New York City, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. s. A.</u>		
13. FATHER'S NAME <u>Peter Von David</u>				14. MOTHER'S MAIDEN NAME <u>Marion Wicker</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Agnes von-David 4109 Paseo</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chc. Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Hypertensive Arterio-Sclerotic</u>		
						DUE TO (c) <u>Heart Disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						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.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____								
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 <u>12/8/56</u> to <u>12/17/56</u> and last saw <u>him</u> alive on <u>12/12/56</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. W. Young</u> (Degree or title) <u>M. D.</u>				22b. ADDRESS <u>1401 S. W. Blvd. N. E. 11.</u>		22c. DATE SIGNED <u>12/17/56</u>		
23b. BURIAL, CREMATION, REMOVAL (Specify)	23c. DATE <u>12-19-1956</u>	23d. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23e. LOCATION (City, town, or county) (State) <u>Hickman Mills, Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar F. H.</u>				25. DATE RECD. BY LOCAL REG. <u>12-17-56</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		

1800 E. Linwood K. C. (Licensed Embalmer's Statement on Reverse Side)

Social, coroner, etc. must use only standard nomenclature in Part I. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Welfare
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Dr. J. W. Young
1401 F. W. B.
20 2-0450

12:30 P - 4

6932
12-17-52

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *James W. Wain*.....

Licensed Embalmer No...4.

P. O. Address...K...S...y...

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