

pt. Health,
, & Welfare
S. Public
alth Service

V. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Jack M. Davis

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1958

44643
STATE FILE NUMBER
5869

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		c. CITY OR TOWN <i>Kansas City</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <i>Research Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>323 Brush Creek Blvd.</i>	
Length of stay in 1b <i>4 1/2 years</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JENNIE</i> Middle <i>HAZEL</i> Last <i>VAN HORN</i>			4. DATE OF DEATH Month <i>Dec.</i> Day <i>11</i> Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 1, 1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Telecom Inc.</i>	9. AGE (In years, less birthday) <i>56</i>
11. BIRTHPLACE (City and state or country) <i>Clinton, Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13a. FATHER'S NAME <i>John D. Van Horn</i>		13b. MOTHER'S MAIDEN NAME <i>Sarah Ellis</i>	
14. NAME OF HUSBAND OR WIFE <i>John H. Van Horn</i>		Address <i>323 Brush Creek Blvd.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>305-07-3307</i>	
17. INFORMANT <i>John H. Van Horn</i>		Address <i>323 Brush Creek Blvd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial asthma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>241 x</i>
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 _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <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 <i>29 April 57</i> to <i>11 Dec 57</i> and last saw her alive on <i>11 Dec 57</i> Death occurred at <i>11 Dec 57</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Jack M. Davis M.D.</i>		22b. ADDRESS <i>Kaytown, Mo.</i>	
22c. DATE SIGNED <i>12 Dec 57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>DEC-12-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Riverside</i>	23d. LOCATION (City, town, or county) (State) <i>Clinton, Indiana</i>
24. FUNERAL DIRECTOR <i>D.W. NEWCOMER'S SONS</i>		ADDRESS <i>1331 BRUSH CREEK KANSAS CITY, MO.</i>	25. DATE RECD. BY LOCAL REG. <i>12-12-57</i>
26. REGISTRAR'S SIGNATURE <i>new minshall</i>			



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 *[Handwritten Signature]*

Licensed Embalmer No. *4421*

P. O. Address *K.C. Mo*

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.