

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021853

STATE FILE NUMBER

2900

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2900

<p>1. PLACE OF DEATH a. COUNTY <u>JACKSON</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u></p>		<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4930 PARK AVE</u></p>		<p>Length of stay in 1b <u>40 YEARS</u></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>LEORA DAVIDSON</u></p>		<p>4. DATE OF DEATH Month Day Year <u>JUNE 6, 1958</u></p>	
<p>5. SEX <u>FEMALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>SEPT. 12, 1870</u></p>	
<p>9. AGE (In years last birthday) <u>87</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u></p>	
<p>11. BIRTHPLACE (City and state or country) <u>NORTH CAROLINA N. S. A.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13a. FATHER'S NAME <u>COLEMAN JENKINS</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>MARTHA C. VESTAL</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>CHARLES G. DAVIDSON</u></p>		<p>Address <u>4930 PARK AVE.</u></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>	
<p>17. INFORMANT <u>MRS. LETA FORD</u></p>		<p>Address <u>KANSAS CITY, MISSOURI</u></p>	
<p>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>Coronary occlusion immediate</u> DUE TO (b) <u>hypertensive heart</u> <u>10 yrs</u> DUE TO (c) <u>W disease</u> <u>42 yrs</u></p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>1948</u>, to <u>6/6/58</u> and last saw her/him alive on <u>6/6/58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.</p>		<p>22a. SIGNATURE (Degree or title) <u>Wm. R. Jackson M.D.</u></p>	
<p>22b. ADDRESS <u>1107 Bryant Bldg</u></p>		<p>22c. DATE SIGNED <u>6/7/58</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE <u>JUNE 10, 1958</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <u>ODESSA CEMETERY</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>ODESSA, MISSOURI</u></p>	
<p>24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>6-9-58</u></p>	
<p>26. REGISTRAR'S SIGNATURE <u>Thera Marshall</u></p>		<p>ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO</u></p>	

All diseases in Part I must be causally related.

Wm. R. Jackson USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION



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 *Norman W. Brown*

Licensed Embalmer No. *4889*

P. O. Address *St. 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.