

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006665
STATE FILE NUMBER

FILED MAR 4 1959 Registration District No. 280 Primary Registration District No. _____ Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>PLATTE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PLATTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parkville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Parkville</u> <u>0830</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7305 MAPLE DR.</u>		Length of stay in 1b <u>35 years</u>	d. STREET ADDRESS (If outside, give location) <u>7305 MAPLE DR.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>W</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>16</u> Year <u>1959</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>NOV. 18-1887</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Builders Service Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ESTERVILLE, IOWA</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	

13a. FATHER'S NAME <u>William Henry Davis</u>		13b. MOTHER'S MAIDEN NAME <u>HELEN MATILDA ANDRUS</u>		14. NAME OF HUSBAND OR WIFE <u>Lavina H. Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>495-03-3498</u>		17. INFORMANT Address <u>RAYMOND W. DAVIS 7305 MAPLE DR.</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>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>57 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>coronary arteriosclerosis</u>		<u>5 yr</u>
	DUE TO (c) <u>generalized arteriosclerosis</u>		<u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Parkville, Mo</u>	COUNTY <u>PLATTE</u>	STATE <u>MISSOURI</u>
21. I attended the deceased from <u>Feb 17 - 1959</u> to <u>Feb 17 - 1959</u> and last saw him alive on <u>Feb 17 - 1959</u> Death occurred at <u>9:45 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated. <u>alive</u>			

22a. SIGNATURE <u>A. P. [Signature]</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>1181st Parkville, Mo</u>	22c. DATE SIGNED <u>2-17-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS-KANSAS CITY, Mo</u>	ADDRESS <u>Feb 19, 1959</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 19, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Elphie Robbins</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.



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 *Vern Lawler*

Licensed Embalmer No. *4915*

P. O. Address *KC 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.