

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009352

STATE FILE NUMBER

FILED MAR 26 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

1230

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4321 Bell		d. STREET ADDRESS (If outside, give location) 4321 Bell	
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Davis		4. DATE OF DEATH Month Day Year Mar 5 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 28-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years, months, days, hours, min.) 79
11. BIRTHPLACE (City and state or country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Oliver		13b. MOTHER'S MAIDEN NAME Martha Monroe	
14. NAME OF HUSBAND OR WIFE W.R. Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give no. or dates of service) NO NONE	
16. SOCIAL SECURITY NO. NO		17. INFORMANT W.R. Davis 4321 Bell K.C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis DUE TO (b) Arteriosclerosis of coronary arteries DUE TO (c) Rheumatoid arthritis - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
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, Year 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 1955 to March 1959 and last saw her alive on March 4, 1959 Death occurred at 845 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) E. I. Slentz, M.D.	
22b. ADDRESS 4620 Nichols Blv., Kansas City, Mo.		22c. DATE SIGNED 3/6/59	
23a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial	23b. DATE MAR 7-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR LATES	1901 OLATHE Bldg. KANSAS CITY KAN	25. DATE RECD. BY LOCAL REG. 3-7-59	26. REGISTRAR'S SIGNATURE Neva Marshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. I. Slentz



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 *Paul R. Williamson*

Licensed Embalmer No. *5009*

P. O. Address *Overland Park, 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.