

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017672  
STATE FILE NUMBER

FILED MAY 29 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2267

300  
-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>KANSAS CITY</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PRAIRIE VILLAGE</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>Cresthaven Conv.</u>		Length of stay in lb <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>8150 3604 W. 71st St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>DAVIS</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20-1870 88</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>4</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>County Meath Ireland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Stephen Roe</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Mulvanny</u>		
14. NAME OF HUSBAND OR WIFE <u>Andrew M. 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 NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>NORMAN DAVIS</u>		Address <u>3604 W. 71st Prairie Villa Km.</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>Acute Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
DUE TO (b) <u>Acute Congestive Failure</u>			<u>24 hrs.</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			<u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4260</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 <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>			

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
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21. I attended the deceased from Feb 1953 to May 1959 and last saw her alive on 5/4/59  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Signature in title) <u>Frank G. O'Connell MD</u>	22b. ADDRESS <u>7951 State Line</u>	22c. DATE SIGNED <u>5/5/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 6-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Marys</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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24. FUNERAL DIRECTOR <u>Leates</u>	ADDRESS <u>1901 Olive Blvd Kansas City 3, Kan</u>	25. DATE RECD. BY LOCAL REG. <u>5-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Wera Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
Frank A. O'Connell Use only black ink or ribbon typewrite if possible  
All diseases in Part I must be causally related.

(2)

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 B. Williamson*.....

Licensed Embalmer No. *5009*.....

P. O. Address *Oveiland Park*.....

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.