

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025076

FILED VS AUG 10 1959

Registration District No. 149 Primary Registration District No. 1032 Registrar's No. 3607 STATE FILE NUMBER

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |   |  |
| a. COUNTY Jackson  |  | a. STATE Missouri   |  | b. COUNTY Jackson   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City        |  | Length of stay in lb 1 Week   |  | c. CITY OR TOWN Bates City                                |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>     |  | d. STREET ADDRESS (If outside, give location) Rural Route |  |
| Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |   |  |   |  |

|                                     |                        |  |                             |                           |                                |            |
|-------------------------------------|------------------------|--|-----------------------------|---------------------------|--------------------------------|------------|
| 3. NAME OF DECEASED (Type or print) |                        |  | 4. DATE OF DEATH            |                           |                                |            |
| First Roy                           |                        |  | Middle A.                   |                           | Last Davis                     |            |
|                                     |                        |  | Month July                  |                           | Day 25                         |            |
|                                     |                        |  | Year 1959                   |                           |                                |            |
| 5. SEX male                         | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Oct 9 1881 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR IF UNDER 24 HR |            |
|                                     |                        |  |                             | Months                    | Days                           | Hours Min. |

|  |  |   |  |   |                                      |                                    |  |
|--|--|---|--|---|--------------------------------------|------------------------------------|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer |  | 10b. KIND OF BUSINESS OR INDUSTRY Retired |  | 11. BIRTHPLACE (City and state or country) Oak Grove Mo |                                      | 12. CITIZEN OF WHAT COUNTRY U.S.A. |  |
| 13a. FATHER'S NAME Saleon Davis  |  |   | 13b. MOTHER'S MAIDEN NAME Sallie Shore |   | 14. NAME OF HUSBAND OR WIFE Deceased |                                    |  |

|   |  |                                     |  |  |  |  |  |
|---|--|-------------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No |  | 16. SOCIAL SECURITY NO. 499-16-1160 |  | 17. INFORMANT Address Hollis Davis Bates City Mo |  |  |  |
|---|--|-------------------------------------|--|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                             |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) Acute Colon Obstruction   |  | about 1 day   |  |
| DUE TO (b) sigmoid acute diverticulitis   |  |   |  |
| DUE TO (c) Perforation  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | PART III. If deceased was female was there a pregnancy in last 90 days.                   |  |
|   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 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  |  | Month, Day, Year  |  |  |  |  |  |

|  |  |  |  |                              |  |        |  |       |  |
|--|--|--|--|------------------------------|--|--------|--|-------|--|
| 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 7-19-59 to 7-25-59 and last saw her alive on 7-25-59. Death occurred at 7-25-59 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                   |                                  |   |  |  |  |  |  |
|--|--|-------------------|----------------------------------|---|--|--|--|--|--|
| 22a. SIGNATURE (Degree or title) J. Hunt         |  |                   | 22b. ADDRESS Prof Bldg 1/4 C, mo |   |  | 22c. DATE SIGNED 7-26-59                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 23b. DATE 7/28/59 |                                  | 23c. NAME OF CEMETERY OR CREMATORY Holiness Cem |  | 23d. LOCATION (City, town, or county) Oak Grove Mo |  |  |  |

|  |  |                      |  |                                      |  |   |  |  |  |
|--|--|----------------------|--|--------------------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR Webb Funeral Home |  | ADDRESS Oak Grove Mo |  | 25. DATE RECD. BY LOCAL REG. 7-26-59 |  | 26. REGISTRAR'S SIGNATURE Vera Marshall |  |  |  |
|--|--|----------------------|--|--------------------------------------|--|---|--|--|--|

DOCUMENT BY AFFIDAVIT OF Hunt M. D. 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

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed William Free

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.