

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023278

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 780

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 5117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED JUL 1 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,		Length of stay in 1b 54 Years	c. CITY OR TOWN St. Joseph, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2420 Felix Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle EDWARD Last DAVIES			4. DATE OF DEATH Month June Day 20, Year 1963
5. SEX Male	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 Dec. 5, 1875
9. AGE (last birthday) 87		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Legislative Adviser		10b. KIND OF BUSINESS OR INDUSTRY Carewags, Wales	11. BIRTHPLACE (City and state or country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Edward A. Davies	
14. MOTHER'S MAIDEN NAME Ann Jones		15. NAME OF HUSBAND OR WIFE Perilla L. Davies	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. SOCIAL SECURITY NO. 15	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO (b) arteriosclerotic + hypertensive DUE TO (c) cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) prostatic hypertrophy. Died 4 days post TUR			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 Hour _____ a.m. _____ p.m. 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 St. Joseph, Missouri
21. I attended the deceased from 6/12/63 to 6/20/63 and last saw him alive on 6/20/63 Death occurred at 8:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Donald Stallard, M.D.		22b. ADDRESS 902 Edmund St.	22c. DATE SIGNED 6/24/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 22, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
23d. LOCATION (City, town, or county) St. Joseph, Missouri		24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.	
25. DATE RECD. BY LOCAL REG. June 26, 1963		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

USE BLACK INK OR TYPEWRITER RIBBON

JUL 15 1962

Permit issued 6-21-63
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211
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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,

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or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eric J. Blum*

Licensed Embalmer No. 4679

P. O. Address St Joseph, 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.