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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13726

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 1438

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4575 Olive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City Mo
(If outside city or town limit, write "RURAL")
(d) Street No.: 4575 Olive
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: David Wilson Davenport
3. (b) If veteran, name war: No
3. (c) Social Security No.: 486-07-4695
4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bessie A Davenport
6. (c) Age of husband or wife if alive: 56 years
7. Birth date of deceased: Jan (Month) 2 (Day) 1883 (Year)

8. AGE: Years 57 Months 2 Days 29 If less than one day ____ hr. ____ min.

9. Birthplace: Freeman (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Stationary Engr.
11. Industry or business: Orpheum Theater Bldg
MOTHER FATHER
12. Name: Jas. B. Davenport
13. Birthplace: — (City, town, or county) Mo. (State or foreign country)
14. Maiden name: Margaret Davidson
15. Birthplace: — (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Bessie A Davenport
(b) Address: 4575 Olive
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Apr - 3 - 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Freeman Mo
18. (a) Signature of funeral director: Mrs C. E. Foster
(b) Address: 918 Brooklyn K.C. Mo
19. (a) April 2, 1940 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1 year 1940 hour 10 minute 12 P.M.
21. I hereby certify that I attended the deceased from Sept. 26 1939 to April 1st 1940 that I last saw him alive on April 1st 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of Rectum	1 year
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Carcinoma of Rectum	
Of autopsy: ✓	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): ✓
(b) Date of occurrence: ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓ (Specify type of place)
While at work? ✓ (e) Means of injury: ✓

23. Signature: Samuel Voegelin M.D. (M. D. or other)
Address: Vineyard Park Hosp. Date signed: 4/2-40

(Licensed Embalmer's Statement on Reverse Side)

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~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.