

FILED APR 23 1945

Registration District No. _____

Primary Registration District No. 1802

Registrar's No. 1682

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:
Willows Hospital-2929 Main St
(If not in hospital or institution, write street number or location) 8 days
(d) Length of stay: in hospital or institution 8 days 14 hrs 40 min
(Specify whether
In this community SAME
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2929 Main St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Diane Davenport

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, bafe
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 29 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 8-0 If less than one day 14 hr 40 min

9. Birthplace Kansas City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation no.e

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Kathleen Davenport
15. Birthplace Maumee Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant A.U. Dysart R.N.

(b) Address 2929 Main St

17. (a) Burial (b) Date thereof 4-14th 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address Kansas City Mo.

19. (a) 4-14-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1945 hour 5:40 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Mar 29
1945, 19____, to Apr 7 1945, 19____;
that I last saw her er alive on Apr 7 1945, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Spina - bifida

Due to _____

Due to _____

Other conditions 157
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H.L. Dwyer (M. D. _____)
Address 315 Alameda Rd Date signed 4-7-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

80308

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Chas E. Wilks

Licensed Embalmer No.....

26441

P. O. Address.....

Kansas City 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 this body is not embalmed, fact should be so stated above.