

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40169

BIRTH NO.		REG. DIST. NO. 38		PRIMARY REG. DIST. NO. 3006		Registrar's No. 318			
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Graves Convalescence</u>				d. STREET ADDRESS (If rural, give location) <u>707 Range Line</u>					
3. NAME OF DECEASED a. (First) <u>James Lee</u> (Type or Print)			b. (Middle) <u>Havenport</u>		c. (Last)				
4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 22-49</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			
8. DATE OF BIRTH <u>Nov 16 1869</u>		9. AGE (In years last birthday) <u>80</u>		10. MONTHS <u>1</u>		11. DAYS <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Boone Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>John Marsh Davenport</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret W. Hoxa Barnes</u>		14. NAME OF <del>HUSBAND</del> OR WIFE <u>Clara C. Thurston</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clara C. Davenport</u>		ADDRESS <u>Columbia</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Endocarditis, recurrent, acute</u>				INTERVAL BETWEEN ONSET AND DEATH  <u>1301</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic hypertrophy + sclerosis.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>indicating retention and infection</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>49</u> , to <u>December 22 1949</u> , that I last saw the deceased alive on <u>Dec 22, 1949</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Geo A. Graves M.D.</u> (Degree or title)				23b. ADDRESS <u>1408 University Ave</u>		23c. DATE SIGNED <u>Dec 23 '49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-24-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pop Top</u>		24d. LOCATION (City, town, or county) (State) <u>Hallsville MO</u>			
DATE REC'D BY LOCAL REG. <u>Dec 23 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		31		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. ...</u> ADDRESS <u>Columbia MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED DEC 27 1949  
District Health Officer No. 9,  
District File Number

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, ~~was~~

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Lynnan K. Spink*

Licensed Embalmer No. *4013*

P. O. Address *Columbia, Md*

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, fact should be so stated above.