

FILED APR 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7474

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 5023 Registrar's No. 25

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| 1. PLACE OF DEATH a. COUNTY <u>ATCHISON</u> <u>0030</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ATCHISON</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-CLAY TWP</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rock Port</u> | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) <u>NONE</u> <u>0030</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NONE</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>MARSHAL</u> | b. (Middle) <u>EUGENE</u> | c. (Last) <u>DAVENPORT</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>3 31 1957</u> |
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| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>12-2-1889</u> | 9. AGE (In years last birthday) <u>67</u> | IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> | IF UNDER 1 HRS. Hours <u></u> Mins. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u> | 11. BIRTHPLACE (State or foreign country) <u>PAGE COUNTY IOWA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> |
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| 13a. FATHER'S NAME <u>JOHN DAVENPORT</u> | 13b. MOTHER'S MAIDEN NAME <u>ANNA WAGNER</u> | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | 16. SOCIAL SECURITY (If yes, give war or dates of service) <u>NO</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Bertrude Suckler</u> | ADDRESS <u>Rock Port Mo</u> |
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| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <u>coronary arteriosclerosis</u> <u>5 yrs</u> DUE TO (c) <u>Generalized arteriosclerosis</u> <u>10 yrs</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocardial infarction - hypertensive</u> <u>5 yrs</u> <u>with disease - chronic nephritis</u> | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) <u>Rock Port Mo</u> |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
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22. I hereby certify that I attended the deceased from 1947, to 3-31, 191957, that I last saw the deceased alive on 3-23, 1957, and that death occurred at 2:30 A m., from the causes and on the date stated above.

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| 23a. SIGNATURE <u>Bertrude Suckler</u> | (Degree or title) | 23b. ADDRESS <u>Rock Port Mo</u> | 23c. DATE SIGNED <u>3-31-57</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>4-2-1957</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>SMITH CEM.</u> | 24d. LOCATION (City, town, or county) (State) <u>Rock Port Mo</u> |
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| DATE REC'D BY LOCAL REG. <u>April 2, 1957</u> | REGISTRAR'S SIGNATURE <u>Theroin V. Schuler</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>BARTHOLMEW MORTUARY</u> | ADDRESS <u>Rock Port</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

44

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gratz Berchataum

Licensed Embalmer No. 3173

P. O. Address Rock Port,

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.