

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35016

STATE FILE NUMBER

FILED NOV 13 1957 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 264

5. 300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #1		Length of stay in 1b 18 yrs. 7 mos.	d. STREET ADDRESS (If outside, give location) Kinlock Park Lix & Hugo
3. NAME OF DECEASED (Type or print) First CHARLES Middle (Mose) Last DAVENPORT		4. DATE OF DEATH Month 11 Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	9. AGE (In years last birthday) 78
11. BIRTHPLACE (City and state or country) Colorado County, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Valentine Davenport		13b. MOTHER'S MAIDEN NAME unk.	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk.		16. SOCIAL SECURITY NO. unk.	17. INFORMANT Address State Hospital #1; Fulton, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO (b) Hypertensive Cardio-vascular disease DUE TO (c) Fracture left humerus			INTERVAL BETWEEN ONSET AND DEATH 9049 47
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 137 COUNTY STATE	
21. Attended the deceased from 8-11-39 to 11-4-57 Death occurred at 11:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Erwin Leonhardt, M.D.	
22b. ADDRESS State Hospital No. 1; Fulton, Mo.		22c. DATE SIGNED 11-4-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-5-57	23b. DATE	23c. NAME OF CENETERY OR CREMATORY anatomical board	23d. LOCATION (City, town, or county) (State) Columbia MO
24. FUNERAL DIRECTOR J. O. Roberts		25. DATE RECD. BY LOCAL REG. Nov-5-1957	26. REGISTRAR'S SIGNATURE Maretha Lawrence

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
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

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.