

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010878

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1524 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED APR 2 1962</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		a. STATE <b>KANSAS</b> b. COUNTY <b>JOHNSON</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>507 MAIN STREET LINEMAN NURSING HOME</b>		c. CITY OR TOWN <b>PRAIRIE VILLAGE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. AGE (last birthday)	
First <b>TAKKEE</b> Middle <b>O</b> Last <b>DAVENPORT</b>		Month <b>MARCH</b> Day <b>14th</b> Year <b>1962</b>		74	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-87</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POSTOFFICE</b>	11. BIRTHPLACE (City and state or country) <b>WARRENSBURG MISSOURI, U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>James Davenport</b>		13b. MOTHER'S MAIDEN NAME <b>Frances</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. ADA DAVENPORT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MRS. ADA DAVENPORT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>				<b>30 min</b>	
DUE TO (b) <b>Arteriosclerotic Coronary thrombosis</b>				<b>30 min</b>	
DUE TO (c) <b>Hypertensive Arteriosclerotic Heart Disease</b>				<b>4 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonia left lower lobe</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE	
21. I attended the deceased from <b>6/15/56</b> to <b>3/14/62</b> and last saw him alive on <b>3/12/62</b> Death occurred at <b>8.10 P</b> m on the date stated above and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert W Hamill M.D.</b>			22b. ADDRESS <b>Kansas City, Mo</b>		22c. DATE SIGNED <b>3/15/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mch. 17, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons</b>			25. DATE RECD. BY LOCAL REG. <b>3.16.62</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

ROBERT W. HAMELL MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Dwight M. Hamill  
240 - 4320 Hamill Blvd  
12:30-5:00

STATE OF MISSOURI

**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 Vern Fowler

Licensed Embalmer No. 4915

P. O. Address KG 7th

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.