MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10544-a

1. PLACE OF DEATH
County Lawrence — Registration District No. 467
Township Lawrence — Primary Registration District No. 42 80
City Aurora Mo (No. ..... St. ..... Ward) — File No. 10544 — Registered No. .....

2. FULL NAME Lowell Arda Davenport

(a) Residence. No. Verona (Usual place of abode) Mo St. ..... Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Mell. Davenport

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 10 - 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	34		14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Selling of P.T. - Indians
(c) Name of employer Washburn Thresher Co

9. BIRTHPLACE (CITY OR TOWN) Verona Mo (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William H. Davenport
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mansfield (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Hannah B. White
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Verona (STATE OR COUNTRY) Ohio

14. INFORMANT Hannah B. Davenport (Address) Verona Mo

15. FILED ....., 19..... B W Smart REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24 1931

17. I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1931, to Mar. 24 1931, that I last saw h[illegible] alive on Mar. 24 1931, and that death occurred, on the date stated above, at 8-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Appendicitis, and
Peritonitis Acute

1B Appendicitis (duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (SECONDARY) Pneumonia (duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Mar 17-31
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Surgical operation
(Signed) B W Smart, M. D.
, 19 (Address) Aurora Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wilson Cemetery Verona Mo — DATE OF BURIAL Mar 26 - 1931

20. UNDERTAKER Phillips & Faucett — ADDRESS Aurora Mo

Mar 30

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 26 1932

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ... St. .....Ward)

2. FULL NAME.....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.