

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

Do not use this space.

21029

1. PLACE OF DEATH

County Jasper Registration District No. 412 File No. _____
 Township West City Primary Registration District No. 30817 Registered No. 74
 City West City Jasper Mo St. _____ Ward _____

2. FULL NAME

Leonia Josephine Davenport
 (a) Residence. No. 2534 Jasper St. _____ (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 13 1911

7. AGE: YEARS 16 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Student
 (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) Osage

10. NAME OF FATHER Geo. W. Davenport

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

12. MAIDEN NAME OF MOTHER Leola Johnson

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

14. INFORMANT (Address) Geo. W. Davenport
Jasper Mo.

15. FILED Apr 78 R. M. Stornant REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 11-05 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Ruptured appendix followed with septic peritonitis
 (duration) _____ yrs. _____ mos. 17 da.

CONTRIBUTORY (SECONDARY) Operation
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 1170

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Margaret T. Raymond M.D.
 (Address) 1170 - First Bldg.

*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 Grant Memorial DATE OF BURIAL 6-14 1928

20. UNDERTAKER Walter T. Davenport ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

