

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

Do not use this space.

42763824

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City, Mo.

Registration District No. 399
Primary Registration District No. 1002
St. Joseph's Hospital

File No. _____
Registered No. _____
Ward) _____

2. FULL NAME

(a) Residence, No. 3811 Wyandotte St.,
(Usual place of abode)

Mrs. Mamie Davenport
5 Ward.
(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 F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 2 21

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Johnson Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER James P. Mar

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

12. MAIDEN NAME OF MOTHER Frances Stephen

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

14. INFORMANT Jahkee O. Davenport
(Address) 3811 Wyandotte

15. FILED 10/16/1929 M. M. Crows
asst. REGISTRAR

B MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 15 1929
17. _____

I HEREBY CERTIFY, That I attended deceased from Oct. 15 1929 to Oct. 15 1929
that I last saw her alive on Oct. 15 1929, and that death occurred, on the date stated above, at 11:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Embolia (Cerebral)

122 A 82 B Dudden
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Operation for Hernia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John O. Stinner, M. D.

76-15-1929 (Address) 3816 Tenth
*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 Forest Hill
Forest Hill DATE OF BURIAL Oct. 17 1929

20. UNDERTAKER 177 Newcomer
ADDRESS St. Mo

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.

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1:30 - 5:30