

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.

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

Do not use this space.

Jul 24 1935

17174

1. PLACE OF DEATH

County *Miller*
Township *Equality*
City *New Bremen* (No.) St. Ward)

Registration District No. *5-14*
Primary Registration District No. *4-3*

File No.
Registered No.

2. FULL NAME

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

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 20 1851*

7. AGE YEARS *84* MONTHS *1* DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *In County Home*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

MOTHER 13. NAME *unknown*

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

15. MAIDEN NAME *unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

17. INFORMANT *J. M. Garner* (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE *Durbin* DATE 19

19. UNDERTAKER *D. J. Ryan* (ADDRESS)

20. FILED 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 2*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *Nov 1934*, 19..... to *April 30*, 1935. I last saw her alive on *April 30*, 1935. Death is said to have occurred on the date stated above, at *10* a. m.

The principal cause of death and related causes of importance were as follows:

apoplexy from hypertension Date of onset

Other contributory causes of importance: *nephritis*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *2*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify *L. M. Garner*, M. D.
(Signed) *J. M. Garner*
(Address) *New Bremen, Mo.*

917 Elm

Delly Run

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

Do not use this space.

1. PLACE OF DEATH

County Miller
Township Equality
City Franklin (No. _____)

Registration District No. 564
Primary Registration District No. 8758

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Francis Davenport

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE U 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.
84 1 _____

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____

11. Total time spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER FATHER
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED Aug 3 1935 W. H. Kover Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 2 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Apoplexy from
hypertension
chronic nephritis
Date of onset _____

Other contributory causes of importance: _____

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) L. M. Garner, M. D.
(Address) W. H. Kover

SUPPLEMENT

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLATE 6

5-1974