

FILED MAR 12 1940  
318

Primary Registration District No. 2001

39  
36  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
504 N. Newton 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Eight years  
years, months or days

8. (a) PRINT FULL NAME Robert H. Davenport

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose Ann Davenport 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased August 15 1854  
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown 9

18. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Matilda Davenport 9

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Rose A. Davenport

(b) Address 504 N. Newton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Home

18. (a) Signature of funeral director Fred C. Thine

(b) Address 1100 Bowersville Ave. S. 40

19. (a) 2/17/40 (Date received local registrar) (b) Chas. J. King (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 504 N. Newton (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14  
year 1940 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from 2,13,40, 19, to 2,14,40, 19, that I last saw him alive on 2,14,40, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, cerebral

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

Signature J. Murch (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 2,17,40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*R. L. Thorne*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo.*

**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 this body is not embalmed, above space should be left blank.