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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED APR 8 1940

Registration District No. 534

Primary Registration District No. 5717

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural-1; U. S. Highway 361
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1-5-1
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Macon; Mo
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Edgar Russell Davenport

3. (b) If veteran, name war World War 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Opal 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 10th 1894
(Month) (Day) (Year)

8. AGE: Years 44 Months 10 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Monroe City Missouri
(City, town or county) (State or foreign country)

10. Usual occupation Beer Salesman

11. Industry or business

MOTHER FATHER { 12. Name David R. Davenport 0
13. Birthplace Marion County Missouri
14. Maiden name Sarah Catherine Mahan
15. Birthplace Marion County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant H. P. Dismitt
(b) Address Monroe City, Mo
17. (a) Removal (b) Date thereof Oct. 11 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Judes Monroe City

18. (a) Signature of funeral director WILSON & SON
(b) Address Monroe City, Mo
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1939 hour 6 minute 30 M.

21. I hereby certify that I attended the deceased from Oct 11 1939 to Oct 11 1939

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Killed in car
Auto wreck at the old Riker
bridge part of New Center in
the
Due to auto wreck
both legs burned off + body
Due to auto wreck

Duration

instant

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy No

PHYSICIAN

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) Accident
(b) Date of occurrence Oct 11 - 1939
(c) Where did injury occur? near New Center Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place

While at work? Yes (Specify type of place) (e) Means of injury Auto Wreck

23. Signature H. West (M. D. or other) H
Address New Center Mo Date signed Oct 11 1939

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

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RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE APR 4 - 1940

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.....

Licensed Embalmer No.

P.O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11658

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 534

Primary Registration District No. 5717

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Macon
(b) City or town. Linn Sus
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRIME FULL NAME

Edgar Russell Davenport

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 10 1 h..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11
year 1939 hour..... minute..... M.

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

Immediate cause of death: Killed in an auto wreck at the old river bridge west of New Cambria. Was almost burned up.

Due to: Collision with fixed object at a concrete bridge on the old River River.

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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.....

23. Signature C. D. West car (M. D. or other)

Address New Cambria Date signed 10/11/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

Registration District No. 534

Primary Registration District No. 5717

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Mason
 (b) City or town Longview (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Edgar Russell Davenport

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased Dec-10 1894
 (Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 1 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Dec 15 (b) Cowart
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month Oct day 11
 year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature C. D. West Cowart
 Address New Madrid Date signed _____
 (M. D. or other)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

HOWENA M...