

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22121

State File No. \_\_\_\_\_

Registration District No. 1149

Primary Registration District No. 5697

Registrar's No. 4

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Pineville (Rural)  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald  
(c) City or town Pineville (Rural)  
(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 William W. Davenport

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 8 4 1870  
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

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

MOTHER FATHER { 12. Name James Davenport  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Betsy Coffee  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Mosier  
(b) Address Jane mo.

17. (a) ~~James Davenport~~ (b) Date thereof 6-22-41  
(Date received local registrar) (Month) (Day) (Year)

(c) Place: burial or cremation Jane mo.

18. (a) Signature of funeral director Lee D Carnell

(b) Address Pineville mo

19. (a) 6-21-41 (b) Lee D Carnell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 21 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 1, 1941, to June 21, 1941;  
that I last saw him alive on May 16, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis

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

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

Other conditions Chronic nephritis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy 1318

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? 4/10/41

(Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

28. Signature John H. ... (M. D. or other) \_\_\_\_\_

Address Pineville Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6;

District File Number 741-1072

Date Filed JUL 11 1940

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**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.**