

FILED NOV 12 1943  
Registration District No. **209**

Primary Registration District No. **3043**

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Elizabeth Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days) All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe **069**  
(c) City or town Shelbina Rural  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) Citizen of foreign country? No. (Yes or No) **1**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Taylor Davenport

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Single  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased May, 29th, 1892  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days     | If less than one day |
|---------|-----------|----------|----------|----------------------|
|         | <u>51</u> | <u>2</u> | <u>4</u> | _____ hr. _____ min. |

9. Birthplace Macon Co. 0 mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Same

MOTHER FATHER { 12. Name Alfred Davenport  
13. Birthplace Ind. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Maratha E. Walker  
15. Birthplace Macon Co. 0 mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Davenport

(b) Address Shelbina, Mo.

17. (a) Burial (b) Date thereof 8-5-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina, Mo.

18. (a) Signature of funeral director Melloni & Bartelme

(b) Address Shelbina, Mo.

19. (a) 9/7/43 (b) R. Worrior  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day Aug  
year 43 hour 8:50 a.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 29  
1943 to Aug 5 1943  
that I last saw him alive on 3rd day 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease  
Duration \_\_\_\_\_

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

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

Other conditions Arteriosclerotic kidney  
(Include pregnancy within 3 months of death)

Major findings: Of operations 1/2/10  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
(b) Date of occurrence 8/7/43  
(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 [Signature] (M.D. or other) \_\_\_\_\_  
Address [Address] Date signed 9/7/43

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

64  
3  
4

**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..... *Ell Hawkins*  
Licensed Embalmer No. *3498*  
P. O. Address *Albina - 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, fact should be so stated above.**