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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22927**

FILED JUL 2 1944
Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **6236**

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Mary Davenport
3. (b) If veteran, name war NO
3. (c) Social Security No. None

4. Sex Female **5. Color or** 3 **6. (a) Single, widowed, married,** 7
race Negro **divorced**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years
7. Birth date of deceased Aug 24 1858
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 15 If less than one day
hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. Nebbert
13. Birthplace _____ (City, town, or county) _____ (State or foreign country) 9
14. Maiden name Lucile
15. Birthplace _____ (City, town, or county) _____ (State or foreign country) 9

16. (a) Informant Miss Joyce

(b) Address 2331 Mullany Pl

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 7-13-44
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J.A. Harrison

(b) Address 2906 Lantion Blvd

19. (a) JUL 13 1944 (Date received local registrar) **J. T. Bessick** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 17
(c) City or town St Louis (If outside city or town limits, write "RURAL") 9
(d) Street No. 1334 Gay St (If rural, give location) 25
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 9
year 1944 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from July 1, 1944, to July 9, 1944;
er July 9, 1944;
that I last saw h. _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Intestinal Obstruction (Volvulus)
route

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) _____ (e) Means of injury _____

23. Signature W. J. Brewer (M. D. or other) _____
Address 2601 N Whittier St Date signed 7/13/44

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

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

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 Jane A. Lammers
Licensed Embalmer No. 4142

P. O. Address St. Louis

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 62369

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(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

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Davenport

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

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

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

7. Birth date of deceased Aug 24 1885
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.

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

8. AGE: Years 85 Months 10 Days _____ If less than one day _____ min. _____

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

Immediate cause of death _____

Due to _____

Due to _____

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) Aug 25 1948 J. F. Buech
(Date of local registration) (Registrar's signature)

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

22927