

V. S. No. 2
00M-5-43
Rev. 5-17-39
I X36871

FILED DEC 22 1944/49
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Krestwood Convalescent Home 2700 Tracy
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 Years**
(Specify whether years, months or days)
 In this community **40 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs Bertha E. Davenport

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

4. Sex Female	5. Color or race Wh	6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Mason Davenport (Deceased)		6. (c) Age of husband or wife if years
7. Birth date of deceased June 26th 1868 <small>(Month) (Day) (Year)</small>		

8. AGE:	Years	Months	Days	If less than one day
	76	5	17	hr. _____ min.

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

10. Usual occupation **Home**

11. Industry or business _____

MOTHER { 12. Name **Lott Scofield**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mildred Rindskopf**
 (b) Address **Wil Wilmette Ill**

17. (a) **Burial**
(Burial, cremation, or removal) (b) Date thereof **12 16th 44**
(Month) (Day) (Year)
 (c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Sylar Funeral Home**
 (b) Address **Kansas City Mo**

19. (a) **12-14-44** (b) **P. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2700 Tracy**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **13th**
 year **1944** hour **3** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Aug 16**
 19**43**, to **Dec. 13** 19**44**
 that I last saw her alive on **Dec. 13** 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death
myocardites
Hepatic Pneumonia
Generalized arterial
sclerosis + Arthritis
Deformans

Due to... **3 days**
 Due to... **years**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
 Of operations **93 d'**
 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)
 (a) Means of injury _____

23. Signature **Thos. C. McHale, M.D.**
(M. D. or health officer)
 Address **4620 Dandip Ave** Date signed **12-14-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. McHale
4620 Indp Ave
Ch 5750

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

Blow E. Heck

Licensed Embalmer No.

4063

P. O. Address

1800 Linwood Blvd.

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.