

FILED MAR 11 1946
Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **178**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1960 Washington Awd. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME ROXIE ANN DAVENPORT

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife UNK

6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased Feb. (Month) 14 (Day) 1873 (Year)

8. AGE: Years 73 Months 0 Days 5
If less than one day: hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business at Home

MOTHER FATHER

12. Name Jack Gordon

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

14. Maiden name UNK

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

16. (a) Informant Willard G. Davenport

(b) Address 1960 Washington, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 2-22-46 (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cem

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield, Mo.

19. (a) 2-22-46 (Date received local registrar)

(b) B. W. E. Handley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo.

(b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1966 Washington 6
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19
year 1946 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 3rd to 19 Feb 1946
that I last saw her alive on 17 Feb 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis Duration 16 days

Due to Pneumonia, acute bronchial

Due to arteriosclerosis, chronic

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 107

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 _____

(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)

(z) Means of injury _____

23. Signature Don Bilsky (M. D. or other) MD

Address Springfield, Mo Date signed 2-19-46

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. *1763*

P. O. Address *Springfield 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.