No. 300
10-47
5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16904

FILED JUN 1 1948

Registration District No. 1948

Primary Registration District No. 3040

Registrar's No. 72

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Livingston Co. Infirmery 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2½ yrs. (Specify whether
In this community Seven years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Livingston 59
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 1222 South St. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country XX 0

3. (a) PRINT FULL NAME Isaiah Davenport

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Margaret A. Davenport

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

7. Birth date of deceased February (Month) 15 (Day) 1864 (Year)

8. AGE: Years 84 Months 3 Days 1 If less than one day hr. min.

9. Birthplace DeWitt Co. (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Laborer

11. Industry or business XX

FATHER
12. Name Pleasant J. Davenport
13. Birthplace XX (City, town, or county) Illinois (State or foreign country) 1

MOTHER
14. Maiden name Samatha Borten
15. Birthplace XXX (City, town, or county) Ohio (State or foreign country) 1

16. (a) Informant Mrs. Daisy Parsons
(b) Address 120 W. Ohio St., Eureka, Kans

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/18/48 (Month) (Day) (Year)
(c) Place: burial or cremation Avalon Cemetery

18. (a) Signature of funeral director Donald R. Gordon
(b) Address Chillicothe, Mo.

19. (a) May-12-48 (Date received local registrar) (b) Francis B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1948 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from Feb 17, 1947, to May 17, 1948; that I last saw him alive on May 16, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Joseph F. Gale (M. D. or other) M.D.
Address Chillicothe, Mo. Date signed May 12, 1948

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Donald F. Gordan

Licensed Embalmer No. 4191

P. O. Address Chillicothe, 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.

No. 2B
—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 187 Primary Registration District No. 8040 Registrar's No. 72

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(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 years, months or days)

In this community

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 Isaiah Davenport

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 15 1866
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 16 year 1948 hour minute M.

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

Immediate cause of death Bronchial pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Joseph F. Gale (M. D. or other) MD
Address Chillicothe, Mo. Date signed 6-8-48

SUPPLEMENTARY

S-16904