

FILED SEP 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30857**

BIRTH NO. _____ REG. DIST. NO. **212** PRIMARY REG. DIST. NO. **3044** Registrar's No. **32**

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Miller	
b. CITY (If outside corporate limits, write RURAL and give township) Edson		c. CITY (If outside corporate limits, write RURAL and give township) Edson 056'	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle) Alvin	c. (Last) DAVENPORT	4. DATE OF DEATH (Month) (Day) (Year) Aug. 31, 1951
-------------------------------------	--------------------------	--------------------------	----------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 16, 1977	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	--

10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bagnell, Mo., U	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	---

13a. FATHER'S NAME James Davenport	13b. MOTHER'S MAIDEN NAME Emma Woods	14. NAME OF HUSBAND OR WIFE Betha Jane Davenport
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME J. W. Davenport	ADDRESS Edson
---	-------------------------------------	--	----------------------

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia cured few day prior to death			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Aug 10, 1951**, to **Aug 31, 1951**, that I last saw the deceased alive on **Aug 31, 1951**, and that death occurred at **3 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Eoshen M D (Degree or title)	23b. ADDRESS Edson Mo	23c. DATE SIGNED Sept 21, 1951
--	------------------------------	---------------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE Sept 2, 1951	24c. NAME OF GEMETERY OR CREMATORY Nashley	24d. LOCATION (City, town, or county) (State) Edson Mo.
--	-------------------------------	---	--

DATE REC'D BY LOCAL REG. Sept. 21, 51	REGISTRAR'S SIGNATURE Alvarotta Walt	25. FUNERAL DIRECTOR'S SIGNATURE Jessie B. Phillips	ADDRESS Edson
--	---	--	----------------------

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

RECEIVED

SEP 11 1951

MILLER COUNTY HEALTH
DEPARTMENT

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Louis D. Phillips

Licensed Embalmer No. 3663

P. O. Address Keokuk

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.