

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1252

STATE FILE NUMBER

FILED FEB 4 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen'l Hosp. #1</b>		Length of stay in 1b <b>12 yrs.</b>	d. STREET ADDRESS <b>1700 Jefferson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Ira</b> Last <b>Davenport</b>			4. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-26-1892</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (City and state or country) <b>Metota, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Joseph P. Davenport</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah Porter</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW I</b>		
16. SOCIAL SECURITY NO. <b>"Unk"</b>			17. INFORMANT Address <b>John P. Davenport: 329 N. Center: Napoleonville, Ill.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Jan. 9, 1957</b> to <b>Jan. 13, 1957</b> and last saw <b>him</b> alive on <b>Jan. 13, 1957</b> . Death occurred at <b>6:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>B. I. Burns, M.D.</b> (Degree or title)			22b. ADDRESS <b>24th &amp; Cherry</b>		22c. DATE SIGNED <b>1-14-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-15-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wheaton Cemetery</b>	
				23d. LOCATION (City, town, or county) (State) <b>Wheaton, Illinois</b>	
24. FUNERAL DIRECTOR <b>Weilert's: 2332 Monitor Pl. K.C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-14-57</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

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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.....  
Signature of Student Embalmer

Signed *B. C. Weleet*

Licensed Embalmer No. *407*

P. O. Address *K. C. S. M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.