

FEDERAL BUREAU OF INVESTIGATION
 DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013653

FILED VS MAR 30 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 826 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u> | | Length of stay in lb <u>3 days</u> | c. CITY OR TOWN <u>Normandy</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hosp.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>St. Louis 7735 Augusta</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lawrence</u> Last <u>Davenport</u> | | | 4. DATE OF DEATH Month <u>Mar.</u> Day <u>8</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-6-1914</u> | 9. AGE (last birthday) <u>45</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Davenport, ? Wilson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Berline Springer</u> | 14. NAME OF HUSBAND OR WIFE <u>Jean Davenport Rayfield</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>yes</u> | 16. SOCIAL SECURITY NO. <u>491-18-1455</u> | 17. INFORMANT <u>Medical Record</u> Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>M edullary Sarcoma</u> | | <u>2 hrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Severe Toxemia</u> | <u>48 hrs.</u> |
| | DUE TO (c) <u>Acute Glomerular Nephritis</u> | <u>?</u> |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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.) |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </u> |
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| 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 |
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21. I attended the deceased from 3/1/60 to 3/8/60 and last saw him alive on 3/8/60
 Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Dr. C. J. Salame D.O.</u> | 22b. ADDRESS <u>7320 St. Louis Ry</u> | 22c. DATE SIGNED <u>3/9/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>3/11/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Callen Kelly</u> | ADDRESS <u>7267 Natural Bridge</u> | 25. DATE RECD. BY LOCAL REG. <u>3-10-60</u> | 26. REGISTRAR'S SIGNATURE <u>J. W. Murphy M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James A. Lamm

Licensed Embalmer No. 4142

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.