

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036040

FILED VS OCT 14 1960

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9705

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1485 Laurel	

3. NAME OF DECEASED (Type or print) First Middle Last Willard Davenport	4. DATE OF DEATH Month Day Year 9 30 60
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1876	9. AGE (last birthday) 84
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ILL.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Charles Davenport	13b. MOTHER'S MAIDEN NAME Ellen Long Fuller	14. NAME OF HUSBAND OR WIFE Single
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 234-22-7151	17. INFORMANT Address Gda Holliman 1485 Laurel St.
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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: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 332X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Old Cerebral Thrombosis, Arteriosclerotic Heart Disease/	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 Month, Day, Year 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
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21. I attended the deceased from 9-3-60 to 9-30-60 and last saw <input checked="" type="checkbox"/> him alive on 9-30-60 Death occurred at 9:35 a.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) Sydney A. Drown, M.D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 10-4-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) 10-7-60	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Father Dixon Ceme	23d. LOCATION (City, town, or county) (State) County MO
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24. FUNERAL DIRECTOR ADDRESS Lawie F. Home 2930 Dickson	25. DATE RECD. BY LOCAL REG. OCT 6 1960	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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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 Leroy H. Panniste

Licensed Embalmer No. 4523

P. O. Address 4251 Wa

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.