

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

357

**1. PLACE OF DEATH**

County Callaway Registration District No. 104  
Township \_\_\_\_\_ Primary Registration District No. 2008  
City Fulton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 4  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Alexander Cave

(a) Residence, No. 411 S.W. 9th St. St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE Nege 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (NAME OF) Mrs Amanda Cave

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>54</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Miner  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

10. NAME OF FATHER Dave Cave

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER DK.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) DK.

14. INFORMANT Mrs Amanda Cave  
(Address) 411 S.W. 9th St. Fulton, Mo

15. Jan 9, 1930 R. N. Crews  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 8, 1930, and that I last saw him alive on Dec 24, 1930, and that death occurred, on the date stated above, at 7:50 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemiplegia (duration) \_\_\_\_\_ yrs. 8 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Injury in mine (duration) \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.

18. WHEN WAS DISEASE CONTRACTED (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS (Signed) [Signature], M. D.  
, 19 \_\_\_\_\_ (Address) Fulton Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Southside Cemetery DATE OF BURIAL Jan 10 1930

20. UNDERTAKER Eli Bee ADDRESS Fulton, Mo

N. B.—Every item of information should be carefully supplied; AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 11 1930

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**1. PLACE OF DEATH.**

County Callaway Registration District No. 104 File No. 357  
 Township ..... Primary Registration District No. 3008 Registered No. ....  
 City Fulton (No. ....) St. .... Ward)

**2. FULL NAME** Alexander Cave

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>m</u>	4. COLOR OR RACE <u>B</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
10. NAME OF FATHER		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., 19....., to ..... 19....., 19....., and that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemiplegia  
discovered in mine  
falling on floor  
 (duration) ..... yrs. 8 mos. ds.

CONTRIBUTORY Injury in mine  
 (SECONDARY) (duration) ..... yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address) Oct 6, 30 R. N. Crews

15. Oct 6, 30 R. N. Crews  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

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