

8 1930

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

Do not use this space.

1. PLACE OF DEATH

County Linn
Township Brookfield
City Brookfield

Registration District No. 496
Primary Registration District No. 3025
(No. 75th S. Burdett Ave. W Ward)

File No. 5592
Registered No. 13

2. FULL NAME

James A. Caven
(a) Residence (No. 75th S. Burdett 3 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 25 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Happily Belle Caven

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5 - 1843

7. AGE YEARS 87 MONTHS 7 DAYS 3 If LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Genl. Farming
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) W. County Ky.
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Caven

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

12. MAIDEN NAME OF MOTHER Margaret Jones

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

14. INFORMANT (Address) Wm L. Collier
175th 2nd Brookfield Mo

15. FILED 2-10-1930 Thos. P. Fore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1930, to Feb. 8, 1930, that I last saw him alive on Feb. 6, 1930, and that death occurred, on the date stated above, at 11 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

arterio Sclerosis
97
10th (duration) — yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Emphysema of Lungs
(duration) — yrs. 1 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

Not at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF —

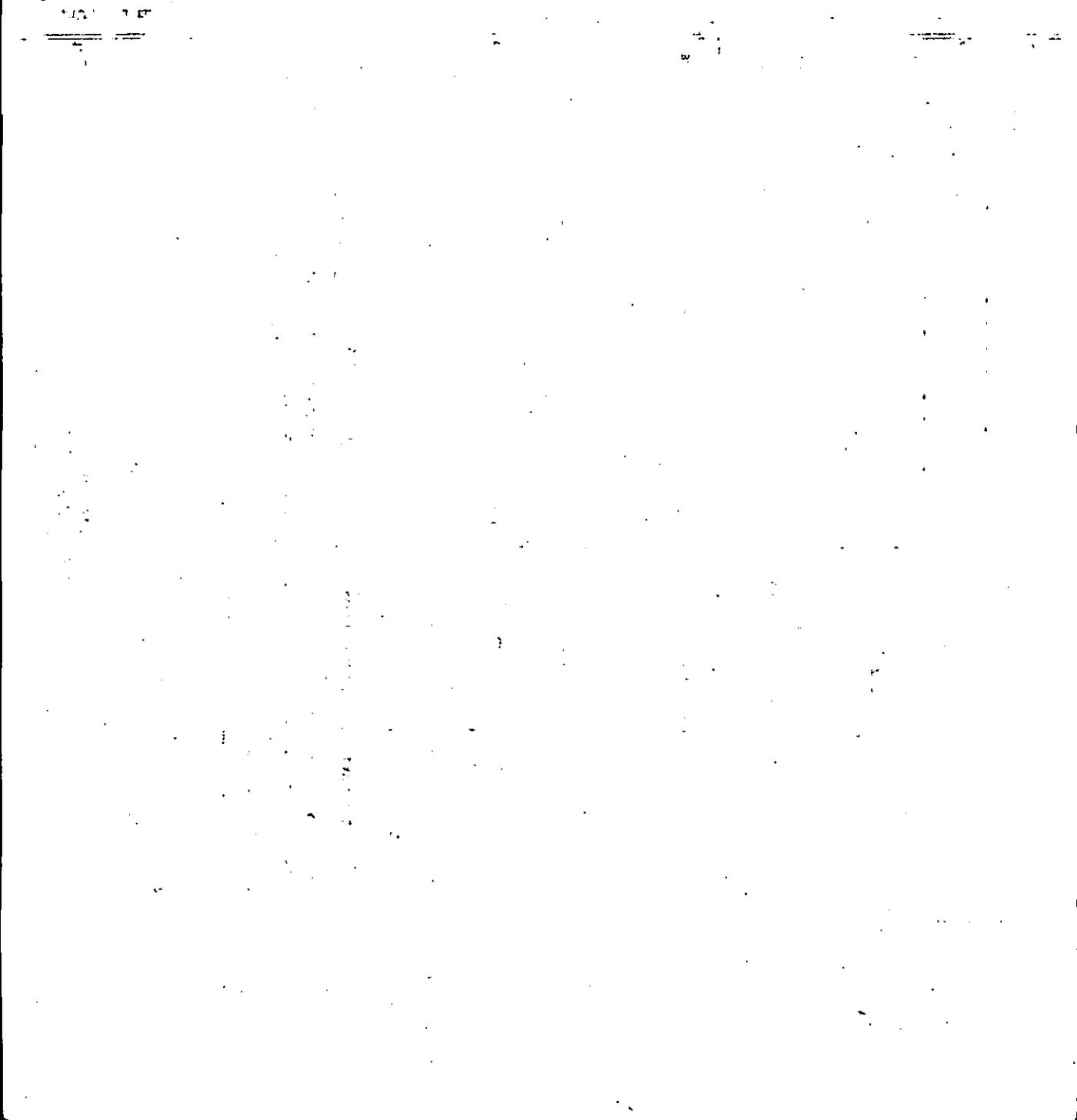
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E. J. Buckley, M. D.
, 19 (Address) Brookfield

*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 Rose Hill Cem. DATE OF BURIAL July 10, 30

20. UNDERTAKER W. Y. Rusk ADDRESS BROOKFIELD, MO.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lincoln Registration District No. 2496 File No. _____
 Township _____ Primary Registration District No. 3025- Registered No. 13
 City Brookfield St. _____ Ward _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5 - 1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 5 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED April 9, 1930 Thos. P. Jore
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ 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.

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

20. UNDERTAKER ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY 1

SUPPLEMENTARY

THE NATIONAL ARCHIVES
COLLEGE PARK, MARYLAND
SERIALS ACQUISITION
1100 COLLEGE PARK DRIVE
BETHESDA, MARYLAND 20814

5-5592