

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

Do not use this space.

28028

1. PLACE OF DEATH

County Registration District No. *91*
Township Primary Registration District No. *33*
City *St. Louis* (No. *De Paul Hospital*) St. Ward) Registered No. *7101*

2. FULL NAME

Catherine Kavanaugh
(a) Residence, No. *5301 Page St.* St. Ward) (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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 90 - - -

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *at Home*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

13. NAME *John Kavanaugh*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

17. INFORMANT (ADDRESS) *Mrs. Watts 5412 Rhodes*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary* DATE *Aug 18* 19*33*

19. UNDERTAKER (ADDRESS) *Catherine J. Donnelly 2840 Kingsley Bldg*

20. FILED *UG 17 1933* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-16* 19*33*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 4* 19*33* to *Aug 16* 19*33*

I last saw *her* alive on *Aug 16* 19*33*. Death is said

to have occurred on the date stated above, at *5:55 P.M.*

The principal cause of death and related causes of importance were as follows:

Embolus Pulmonary Date of onset *1869*
186A
194B
186A

Other contributory causes of importance:
Myocarditis acute
Fr. Femur, Anterior shaft
RT.

Name of operation *none* Date of *1869*
What test confirmed diagnosis? *X Ray* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *acc* Date of injury *1933*

Where did injury occur? *St. Louis, Mo.* (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *slipped on stairs and fell*
Nature of injury *fractured femur*

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) *W. H. A. Stone* M. D.
(Address) *3534 Washington Blvd.*

SEP 26 1933

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

2802 28

1. PLACE OF DEATH

County Registration District No. 791
Township Primary Registration District No. 1003
City St. Louis (No., St. Ward)

File No.
Registered No. 7104

2. FULL NAME

Catherine Wavernaugh

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 18 19

J. Bedeck
Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16 1933

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:

fr. femur enter to Phanterie Rt.

Name of operation Date of.....

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 8/4, 1933

Where did injury occur? at residence (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fell from top of porch

Nature of injury fracture of femur

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed), M. D.

(Address)

SUPPLEMENTARY

Date of onset

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY

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