

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Isolation Hosp**)

File No. **19005**
Registered No. **5552**
St. Ward)

2. FULL NAME *Russell Cavett*

(a) Residence, No. **1916 Carr** St. **21** Ward.

Length of residence in city or town where death occurred **4** yrs. **6** mos. **26** ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *colored* 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) *Nov. 4, 1931*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 6 26

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

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) *St. Louis Missouri*

13. NAME *Carter Cavett*

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

15. MAIDEN NAME *Yvette Shelby*

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

17. INFORMANT *Leona Burns* (ADDRESS) *3600 Arsenal*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Father Duchesne* DATE *6/3* 19 *34*

19. UNDERTAKER (ADDRESS) *2827 W. Brown*

20. FILED *N-4133* 19 *34* *Joe J. Bredeck* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 30, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *May 26* 19 *34* to *May 30* 19 *34*

I last saw him alive on *May 30* 19 *34*. Death is said

to have occurred on the date stated above, at *10:25* p.m.

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

*Diphtheria Neck
10 - Fat embolism
Tubercle Myocarditis 10
15 20*

Other contributory causes of importance:

Cerebral Abscess, Related

Collection of Pus

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? *No*

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

Accident, suicide, or homicide?..... Date of injury....., 19.....

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

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

Manner of injury..... Nature of injury.....

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

If so, specify..... (Signed) *John Scherbaum* M.D.

(Address) **ISOLATION HOSPITAL**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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