

RECEIVED FEB 7 1939

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

3852  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
 (b) Township \_\_\_\_\_ Primary Registration District No. 200 Registered No. 48  
 (c) City Brook Lawn (d) Street No. 6220 GREER St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLIAM JOSEPH CAVANAUGH

(a) Residence, No. 6220 GREER St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 HELEN CAVANAUGH  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 1, 1887  
 7. AGE YEARS 51 MONTHS 8 DAYS 3 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ST. LOUIS  
 9. Industry or business in which work was done, as saw mill, bank, etc. STAR-TIMES  
 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) Mo.

FATHER 13. NAME JOHN CAVANAUGH

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) IRELAND

MOTHER 15. MAIDEN NAME CATHERINE GRIFFIN

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) ENGLAND

17. INFORMANT (ADDRESS) MRS. HELEN CAVANAUGH  
6220 Greer

18. BURIAL, CREMATION, OR REMOVAL PLACE VAL HALLA DATE JAN 7, 1939

19. FUNERAL DIRECTOR (NAME) L.M. MULLEN  
(ADDRESS) 5165 DELMAR BLVD.

20. Local Registrar J.R. Meyer

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN. 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1918, to Jan 4, 1939  
 I last saw him alive on Jan 4th, 1939. Death is said to have occurred on the date stated above, at 11:00 a.m.  
 The principal cause of death and related causes of importance were as follows:

abscess of lungs  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Streptococcus Hemolyticus

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical 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) W. Hampton Park, M. D.  
 (Address) 214 21st St. Ottawa, 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.

JAN 10 1939  
 JAN 8 1939

11413

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed Howard F. Rowland

Licensed Embalmer No. 9114

P. O. Address St Louis Mo

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

3832  
Do not use this space.

1. PLACE OF DEATH *St Louis*

(a) County *St Louis* Registration District No. *784*

(b) Township *Prine Lawn* Primary Registration District No. *200* Registered No. *48*

(c) City *Prine Lawn* (d) Street No. \_\_\_\_\_ St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.

2. PRINT FULL NAME *William Joseph Caranagh*

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

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) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

*51 8 3*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as 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) \_\_\_\_\_

13. NAME \_\_\_\_\_

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

15. MAIDEN NAME \_\_\_\_\_

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

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED *1-6* 19*29* *G. P. Mays* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-4* 19*29*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ 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:

*abscess of lung*

*Streptococcus*

Other contributory causes of importance: \_\_\_\_\_

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? \_\_\_\_\_ 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) *W. Hampton Nash*, M. D.

(Address) *214 N. 7th St. St. Louis Mo.*

SUPPLEMENTARY  
 Report  
 No. \_\_\_\_\_

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

REGISTRARS SMALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

