

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15978
Registrar's No. 92

Registration District No. 773

Primary Registration District No. 6018A

1. PLACE OF DEATH:
(a) County St. Francois Co. St. Francois
(b) City or town Near Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 4
(If not in hospital or institution, write street number or location) 5
(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME John William Cavey 180
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Bertha Smith
6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased 1 31 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 13
If less than one day hr. _____ min. _____

9. Birthplace Boone Co. Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name John Thomas Cavey

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Cotton

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records of State Hospt. #1
(b) Address Farmington, Mo.

17. (a) Buried (b) Date thereof April 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crocker, Mo.

18. (a) Signature of funeral director J. L. ...
(b) Address Crocker, Mo. 699

19. (a) April 16 40 (b) J. L. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pulaski Co.
(c) City or town Jackson
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14
year 1940 hour 2 minute _____ A. M.

21. I hereby certify that I attended the deceased from 4-1- 1940, to 4-14 1940
that I last saw him alive on 4-13 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Arteriosclerosis with psychosis (unc) and terminal apoplexy (4-6-40)
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no
Of autopsy no

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. Tivis Graves, Jr. (M. D. or other M. D.)
Address Farmington, Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....

Paul B Hooper

Licensed Embalmer No..... *3261*

P. O. Address..... *Proctor, 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.