

S. No. 2  
1-4-41  
5-17-39  
I X26390

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4817

0  
7  
9

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4431 Vista Ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME John Thomas Lavin

3. (b) If veteran, name war US

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Late Bridget Lavin

6. (c) Age of husband or wife if alive 150 years

7. Birth date of deceased June 15th 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>about 80</u>			hr. min.

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

10. Usual occupation City water Dept.

11. Industry or business retired 6 yrs

MOTHER FATHER { 12. Name Peter Lavin

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

14. Maiden name

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

16. (a) Informant E. J. Helge

(b) Address 5018 Parker Ave

17. (d) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Gregory H. Mortuaries

(b) Address 4228 So. T. P. Highway

19. (a) Jan 10 1941 (Date received local registrar)

(b) J. J. O'Connell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4431 Vista Ave  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10th  
year 1941 hour 2 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 9, 1941,  
2nd, 1941, to June 9, 1941;  
that I last saw him alive on June 8, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lip  
Carcinomatous

Duration 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: none

Of operations none

Of autopsy no

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) no

(b) Date of occurrence 7-20

(c) Where did injury occur? no  
(City or town) (County) (State)

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

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury

23. Signature Samuel Thure (M. D. or other) M.D.

Address 508 1/2 Grand Blvd. Date signed 6/20/41

Dr. Robert Johnson  
Metrop Bldg 2-3

**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..... *Edwin M. Bennett* .....  
Licensed Embalmer-No..... *3024* .....  
P. O. Address.....

**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, fact should be so stated above.**