

FILED MAY 12 1945

Registration District No. 174

Primary Registration District No. 3035

4
3
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 William Lewis Caves

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eliza Caves 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased May 10 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation Pensioner

11. Industry or business

12. Name Elijah Caves

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

14. Maiden name Sarah Bolderjack

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

16. (a) Informant Mrs. Eliza Caves

(b) Address 305 Highland ave

17. (a) Burial (b) Date thereof 4-15-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director: George T. Sorens

(b) Address Lexington Mo

19. (a) April 15-45 (b) Mrs. Fred Schuab
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Lexington 511
(If outside city or town limits, write "RURAL") 3
(d) Street No. 305 Highland ave 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 13th
year 1945 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 15 1945 to Apr 13 1945; that I last saw him alive on Apr 10 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral occlusion Duration System

Due to Chronic Myocarditis and arteriosclerosis and years

Due to.....
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 9/30
Of autopsy.....
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?.....

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

23. Signature W. R. K. Shaw (M. D. or other)
Address Lexington Mo Date signed 4/14/45

115-8

RECEIVED

District Health Officer No. 3,

District File Number _____

Date Filed 5/11/45

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 George Green

Licensed Embalmer No. 4720

P. O. Address Lexington 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, fact should be so stated above.