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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35531

FILED DEC 12 1945

Registration District No. 318 Primary Registration District No. 1006 Registrar's No. 10588

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY SANITARIUM
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mos 8das. (Specify whether years, months or days)
In this community 37 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2120 So. Grand Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME KATHRYN LAVENDER

3. (b) If veteran, name war No.

3. (c) Social Security No. 490-22-7550

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Fred M. Lavender

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased August (Month) 12 (Day) 1889 (Year)

8. AGE: Years 56 Months 3 Days 23 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wm. H. H. Myers
13. Birthplace not known (City, town, or county) Australia (State or foreign country)

MOTHER
14. Maiden name Kathryn Sullivan
15. Birthplace not known (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Dr. Fred M. Lavender
(b) Address University Club Bldg.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calloway, Co., Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) (Date received local registrar) (b) J. F. Burdick (Registrar's signature)

DEC 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 5th Year 1945 hour 1:15 minute A.M.

21. I hereby certify that I attended the deceased from May 7th 45 to December 5 45 that I last saw her alive on December 5 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebro-Vascular Accident	11/30/45
Organic Brain Disease with	
Hypertensive Encephalopathy	
	1945x
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes

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 Anthony K. Benak (M. D. or other)
Address 5300 Arsenal Date signed 12/4/45

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No.....

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.