S. No. 2
0M—2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1945

State File No. 42373

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 29 B/2

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

96
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1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 120 DAYS (Specify whether
In this community LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ~~St. Louis~~ OO.

(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3029 WALTON PLACE 9
(If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME CAVANAUGH, LORETTA JANE

3. (b) If veteran, name war —

3. (c) Social Security No. 500-18-9161

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased AUG. (Month) 28 (Day) 1910 (Year)

8. AGE: Years 35 Months 3 Days 28 If less than one day ___ hr. ___ min.

9. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)

10. Usual occupation FOOD HANDLER

11. Industry or business

FATHER
12. Name JESSIE JONES
13. Birthplace — (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name LIGGIE POSTEN
15. Birthplace — (City, town, or county) MO. (State or foreign country)

16. (a) Informant HOSPITAL RECORDS
(b) Address ROBERT KOCH HOSPITAL

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home
(b) Address 4828 Natural Bridge Blvd.

19. (a) 12-28-45 (Date received local registrar) (b) E.G. McGannon M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 26
year 1945 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from 5-11, 1945 to 12-26, 1945
that I last saw her alive on 12-25-, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic pulmonary tuberculosis	1 1/2 yr
Due to	
13 b	
Due to	
Other conditions Tuberculous laryngitis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 Bernard Friedman (M. D. or other) M.D.
Address Koch Hosp., Koch, Mo. Date signed 12-26

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph Leighton

Licensed Embalmer No. 4275

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, fact should be so stated above.