

S. No. 2
4-5-43
5-17-39
I X38671

FILED APR 10 1946 STANDARD CERTIFICATE OF DEATH

State File No. 8540

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 357

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: St Josephs Hospital &
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether years, months or days)

In this community 2 months 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell

(c) City or town HAMILTON
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Cavanaugh, Michael

3. (b) If veteran, name war _____

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
year 1946 hour 5 minute 10 M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Bertrude Cavanaugh

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

7. Birth date of deceased: Dec 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 2 1946 to May 10 1946 that I last saw him alive on May 10 1946 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 2 Days 14
If less than one day _____ hr. _____ min.

Immediate cause of death: Myocardial (Chr)

Due to Senility

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

10. Usual occupation Retired Farmer

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name Michael Cavanaugh

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

14. Maiden name Eliza Lawler

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Michael Cavanaugh Decided

(b) Address Hamilton, Mo. - 4 miles before gate to the Hospital

17. (a) Burial (b) Date thereof May 10, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem Hamilton, Mo

18. (a) Signature of funeral director Frank Turner Home

(b) Address Hamilton 760

19. (a) May 30, 1946 (b) W. H. Kolbe
(Date received local registrar) (Registrar's signature)

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

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

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

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

(d) While at _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. H. Kolbe (M. D. or other) _____
Address Central Mo Date signed 8/11/46

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

MOTHER FATHER

NOV 20 1946

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. 1.....

working under my personal supervision.

Signed

J. M. Brown

Licensed Embalmer No. *3052*

P. O. Address *Hamilton 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.