

S. No. 2
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5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23400**

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **862**

1. PLACE OF DEATH:
(a) County **St. Joseph**
(b) City or town **St. Joseph**
(c) Name of hospital or institution: **State Hospital # 7 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 years mos 2 days**
In this community **8 yrs - 2 mos - 2 da**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Clay**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **7**
(If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Theodosia Cave**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **Not**
4. (a) Sex **Female** 5. Color of hair **White**
6. (a) Single, widowed, married, divorced **widowed**
(b) Name of husband or wife **Phil Cave** 6. (b) Age of husband or wife if alive **Deceased**
7. Birth date of deceased **aug 14 1857**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **15**
year **1947** hour **3** minute **10** - P.M.
21. I hereby certify that I attended the deceased from **Jan 1st 1947 to 7-15 1947**
that I last saw her alive on **7-15 1947**
and that death occurred on the date and hour stated above
Immediate cause of death **Myocarditis** Duration **1 week**

8. AGE: Years **89** Months **11** Days **1**
If less than one day hr. min.
9. Birthplace **Lawson Mo**
(City, town, or county) (State or foreign country)

Due to **arteriosclerosis years +**
Due to **advanced age**

10. Usual occupation **House work**
11. Industry or business **at home**
12. Name **John F. Garrett**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Ernie Thompson**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy **autopsy**
Physician _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Cher Cave**
(b) Address **Kearney Mo**
17. (a) **Burial** (b) Date thereof **7-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Kearney Mo Mt Liberty**
18. (a) Signature of funeral director **Leonard Fay**
(b) Address **Kearney Mo**
19. (a) **July 17, 1947** **L. C. Jenkins**
(Date received by registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place) _____
(e) Means of injury _____
23. Signature **L. C. Jenkins** (M, D, or other) _____
Address **State Hospital # 7** Date signed **7-15-47**

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

MOTHER FATHER

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 Leonard Fry
Licensed Embalmer No. 1677
P. O. Address Kearney 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.