

No. 300
-10-47
5-17-39
I 3905

#73473
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 30 1948

MISSOURI CERTIFICATE OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13941
Registrar's No. 3729

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days (Specify whether
In this community 25 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 600
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2802 Lafayette Avenue
Memorial (If rural, give location)
(e) Citizen of foreign country? 23 no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DONALD CAVIECY
3. (b) If veteran, name war Nil 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 19th
year 1948 hour 1 minute 50 A. M.
21. I hereby certify that I attended the deceased from 3/29/48
19 to April 19th 1948
that I last saw him alive on April 19th 1948
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Opal 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 24, 1901
(Month) (Day) (Year)

Immediate cause of death Biliary Cirrhosis Duration
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy Cirrhosis of liver
BILE NEPHROSIS

8. AGE: Years Months Days If less than one day
46 7 25 hr. _____ min.

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

10. Usual occupation Switchman

11. Industry or business Terminal R R

12. Name William L. Caviocy

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

14. Maiden name Rose Barnes

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

16. (a) Informant Mary Caviocy

(b) Address 2802 Lafayette Avenue

17. (a) burial (b) Date thereof 4-21-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Annapolis, Missouri

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) (Date received local Form 45) (b) J. F. Bruneck (Registrar's signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) [Signature]
Address 1515 Lafayette 4/19/48 Date signed

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.....

W. Cooper

Licensed Embalmer No.....

3830

P. O. Address.....

2301 Lafayette

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.