

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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1003

State File No. 21686
Registrar's No. 5012

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN St. Louis		2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vahle Manor Nursing Home				d. STREET ADDRESS (If rural, give location) 5 5903 Cates Ave. 0			
3. NAME OF DECEASED (Type or Print) a. (First) Alice		b. (Middle) A.		c. (Last) Kavanaugh		4. DATE OF DEATH (Month) (Day) (Year) June 6, 1950	
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S. 0		8. DATE OF BIRTH Feb. 4, 1872	
9. AGE (In years, last birthday) 78		IF UNDER 1 YEAR Months 4 Days 2		IF UNDER 10 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Phil Kavanaugh		13b. MOTHER'S MAIDEN NAME Margaret McClusky		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Phil J. Kavanaugh, 5903 Cates Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of left lung</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 163X			
22. I hereby certify that I attended the deceased from Feb. 4, 1950 , to June 6, 1950 , that I last saw the deceased alive on June 4, 1950 , and that death occurred at 2:30 am from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert P. ... M.D.				23b. ADDRESS 508 N. Grand Ave.		23c. DATE SIGNED 6/6/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 8, 1950		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUN 7 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anthony Donnelly 3840 Lindell Blvd.			

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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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.....

working under my personal supervision.

Student Embalmer No.....

Signed..... *W. Van Matre*

Signed.....
Student Embalmer

Licensed Embalmer No. *2825*

P. O. Address *4340 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.