

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7533

State File No.

FILED MAR 20 1951

BIRTH NO. _____		REG. DIST. NO. <u>37</u>		PRIMARY REG. DIST. NO. <u>4049</u>		Registrar's No. <u>19</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Centralia</u>		c. LENGTH OF STAY (in this place) <u>6 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Rocky Fork</u>		0150	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Allen St.</u>				d. STREET ADDRESS (If rural, give location) <u>near Hallsville</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER CAVANAUGH</u> b. (Middle) <u>LA FORCE</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>3-13-51</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-24-1867</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u>	IF UNDER 1 WEEK Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gardening</u>		11. BIRTHPLACE (State or foreign country) <u>Boone County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W. P. La Force</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Grady</u>		14. NAME OF HUSBAND OR WIFE <u>Nova Berry La Force</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. W. C. La Force Centralia, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Degeneration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Hypertensive (Renovascular)</u> DUE TO (c) <u>Chronic Nephritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>asthma (Bronchial)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>years</u> <u>years</u> <u>years</u>
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		592X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u> </u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>7-2-45</u> , to <u>3-13-51</u> , that I last saw the deceased alive on <u>3-12-51</u> , 19 <u>51</u> , and that death occurred at <u>12:24</u> A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. C. Baker, M.D.</u>				23b. ADDRESS <u>2 Centralia, Mo</u>		23c. DATE SIGNED <u>3-13-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-14-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Boone County, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Mar 14-1951</u>		REGISTRAR'S SIGNATURE <u>Maud McBrider</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bill Meador</u>		ADDRESS <u>Centralia, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 3-19-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 3-19-51 _____

MAR 20 1951

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 _____

Louis M. Meador

working under my personal supervision.

Student Embalmer No. 379

Signed Louis M. Meador
Student Embalmer

Signed A. E. Booth

Licensed Embalmer No. 4087

P. O. Address Sturgeon - 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.