

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2961

FILED JAN 26 1954 BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0265

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2109	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 10 3123 a N. Newstead 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St John's			
3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) KAVANAUGH c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) JAN 10 1954	
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 7/26/1907
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Al's Cafe	11. BIRTHPLACE (State or foreign country) St. Louis Mo 0
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Oswald Lee		13b. MOTHER'S MAIDEN NAME Carrie Skinner	14. NAME OF HUSBAND OR WIFE Eugene A Kavanaugh
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 488-18-6359	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kenneth Kavanaugh 6425 Hobart (17)
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF LARYNX  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. BRONCHOPNEUMONIA	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 161X	
22. I hereby certify that I attended the deceased from JAN 9, 1954, to JAN 10, 1954, that I last saw the deceased alive on JAN 10, 1954, and that death occurred at 6:35 P. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl W. Lammers M.D.		23b. ADDRESS 307 S. EUCLID	23c. DATE SIGNED JAN 11, 1954
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 13 54	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo
DATE REC'D BY LOCAL REG. JAN 11 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette	

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

**STATEMENT BY LICENSED EMBALMER**

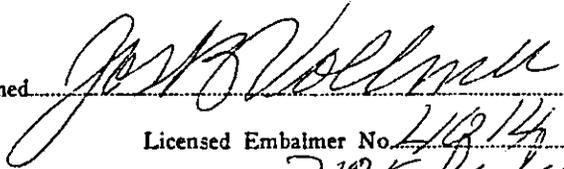
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....



Licensed Embalmer No. 41814

P. O. Address 3125 La. Street

**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.