

FILED NOV 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36833**

BIRTH NO. _____ REG. DIST. NO. **72** PRIMARY REG. DIST. NO. **3014** Registrar's No. **98**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY OR TOWN Liberty	c. LENGTH OF STAY (in this place) 15 yrs	c. CITY OR TOWN Liberty	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 509 E. Mill St		STREET ADDRESS (If rural, give location) 509 E. Mill St	

3. NAME OF DECEASED (Type or Print) EDWARD D CAVENDER			4. DATE OF DEATH Nov. 24-1954		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)
5. SEX male		6. COLOR OR RACE White	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec 31-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Swallower		10b. KIND OF BUSINESS OR INDUSTRY Rx	9. AGE (In years last birthday) 73		11. BIRTHPLACE (City and State or Foreign Country) Holt Mo.
13a. FATHER'S NAME Robert Cavender		13b. MOTHER'S MAIDEN NAME Mary Ann Stevens		14. NAME OF HUSBAND OR WIFE Nellie P. Cavender	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 70707-6886		17. INFORMANT'S SIGNATURE OR NAME Alma Miller, Liberty, Mo.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stokes-Adams Syndrome ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Levanary Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 12 hr. Indefinite

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?	

22. I hereby certify that I attended the deceased from **Jan**, 19**52**, to **Nov 24, 1954**, that I last saw the deceased alive on **Nov 22, 1954**, and that death occurred at **7 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Glenn W. Harrison M.D.		23b. ADDRESS Liberty, Mo.		23c. DATE SIGNED 11-26-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 26-54		24c. NAME OF CEMETERY OR CREMATORY Fairview	
DATE REC'D BY LOCAL REG. Nov. 26, 1954		REGISTRAR'S SIGNATURE Mabel Graham		25. FUNERAL DIRECTOR'S SIGNATURE Church-Creswell Co. Liberty, Mo.	

24d. LOCATION (City, town, or county) (State) **Liberty Mo.**

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

JUL 19 1955

JUL 31 1955

DEC 1955

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.....
Signature of Student Embalmer

Signed.....
John Lombard

Licensed Embalmer No. 444
P. O. Address.....
Liberty

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Facts to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.