

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25357

State File No. _____

FILED JUL 29 1957

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 245

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HANNIBAL</u>		c. CITY OR TOWN <u>FRANKFORD</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>15 days</u>		STREET ADDRESS (If rural, give location) <u>0830</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BECKY THATCHER REST HOME</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>BERT</u> c. (Last) <u>CAVERLY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 13 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 15 1874</u>		9. AGE (In years last birthday) <u>83</u> if UNDER 1 YEAR Months _____ Days _____ if UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>PIKE Co. MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>CHARLES CAVERLY</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH GILMORE ROTH STARKS CAVERLY</u>		14. NAME OF HUSBAND OR WIFE _____	
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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. _____		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. Bee Starks FERGUSON 231 Mo.</u>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronaria of bladder</u> 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.		INTERVAL BETWEEN ONSET AND DEATH <u>3 md</u>	
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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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) _____		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 7-1, 1957 to 7-13, 1957, that I last saw the deceased alive on 7-13, 1957 and that death occurred at 805A m., from the causes and on the date stated above.

23a. SIGNATURE <u>P M Strong MD</u> (Degree or title)		23b. ADDRESS <u>Hannibal Mo</u>		23c. DATE SIGNED <u>7-13-57</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>July 15-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Farrison Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Frankford Mo.</u>	

DATE REC'D BY LOCAL REG. <u>7-23-57</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckey</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>W. H. Ferguson Frankford Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 26 1957
MARION CO. HEALTH DEPT.
DATE FILED JUL 26 1957

DEC 11 1957

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 *Joe Lucas Reynolds*

Licensed Embalmer No. *409*

P. O. Address *Frankford*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.