

THE DIVISION OF HEALTH OF MISSOURI
STANDARD REGISTRATION OF DEATH

58-031418

STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED SEP 8 1958 Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 139

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		c. CITY OR TOWN <u>Arrow Rock</u> <u>0970</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR PHYSICIAN <u>Fitzgibbon</u>		d. STREET ADDRESS (If outside, give location) <u>Arrow Rock, Mo.</u>	
Length of stay in 1b <u>2days</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucien Cavil</u>			4. DATE OF DEATH Month Day Year <u>August 29th '58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14th/1890</u>	9. AGE (In years, last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Park</u>		11. BIRTHPLACE (City and state or country) <u>Arrow Rock, Saline, Mo.</u>	
13. FATHER'S NAME <u>Lewellen Cavil</u>			14. MOTHER'S MAIDEN NAME <u>Charrolette Brown</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>493-12-3218</u>		17. INFORMANT Address <u>Mrs. Katherine Cavil, Arrow Rock, Mo.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vas Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>2 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Sinus Thrombosis</u>	
	DUE TO (c) <u>331X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>Aug 28</u> to <u>Aug 29</u> and last saw her alive on <u>Aug 29</u> . Death occurred at <u>4:30p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Print or type) <u>J. H. Hunsfield</u>	22b. ADDRESS <u>Marshall, Mo.</u>	22c. DATE SIGNED <u>9-2-58</u>

23a. BURIAL (Specify) <u>Burial</u>	23b. DATE <u>9/3/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sappington, Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Arrow Rock Saline Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Georgett Green, Marshall, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-2-58</u>	26. REGISTRAR'S SIGNATURE <u>Cecil G. Reed</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

527

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 *Georgette Green*

Licensed Embalmer No. *427*

P. O. Address *Marshall*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.