Health, Welfare Public Service

300 1-57

FILED JAN 26 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000436

STATE FILE NUMBER

Registration District No. 46 Primary Registration District No. 4063 Registrar's No. 2

1. PLACE OF DEATH
a. COUNTY: Caldwell
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Hamilton — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in 1b: 15 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Caldwell
c. CITY OR TOWN: Hamilton — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Charles Middle: Cicero Last: Kavanaugh

4. DATE OF DEATH Month Day Year: 1/8/1959

5. SEX: Male **6. COLOR OR RACE:** White **7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 3/10/1883

9. AGE (In years last birthday): 75 — 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): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Allen Co. Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: E.R. Kavanaugh
13b. MOTHER'S MAIDEN NAME: Anna C. Baxley
14. NAME OF HUSBAND OR WIFE: Rebecca Kavanaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: E. C. Kavanaugh Address: Hamilton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic C-V. disease — INTERVAL BETWEEN ONSET AND DEATH: 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4221

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION Hamilton **COUNTY** Caldwell **STATE** Mo.

21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M Daley MD.
22b. ADDRESS: Hamilton, Mo.
22c. DATE SIGNED: 1-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/10/1959
23c. NAME OF CEMETERY OR CREMATORY: Cowgill Cemetery
23d. LOCATION (City, town, or county) (State): Cowgill, Mo.

24. FUNERAL DIRECTOR: Morris A. Bram **ADDRESS:** Hamilton, Mo.
25. DATE RECD. BY LOCAL REG.: 1-19-59
26. REGISTRAR'S SIGNATURE: Gladys Jones

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Frank Daley M.D.

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 Morris A. Bram

Licensed Embalmer No. 3918

P. O. Address Hamilton

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.