

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002808
STATE FILE NUMBER

2 921
Registrar No.

300
-57

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes No

c. CITY OR TOWN St. Louis Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3845 Maffitt Length of stay in 1b 75 Yrs. d. STREET ADDRESS 2269 1913 Dodier (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Sophie Middle _____ Last Cavanaugh

4. DATE OF DEATH Month 1 Day 25 Year 59

5. SEX female 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH 12-20-1876 9. AGE (In years last birthday) 82 10. FUNDER 1 YEAR Months 1 Days 5 IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) Iowa 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE John Cavanaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no. or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 497-20-7478 17. INFORMANT Fred DeWitt Address 3845 Maffitt

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b) Coronary Sclerosis
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201

INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO 2

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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____

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 _____ COUNTY _____ STATE _____

21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at 1105 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrik J. Taylor Coroner 22b. ADDRESS 1300 Clark 22c. DATE SIGNED 1-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 1-28-59 23c. NAME OF CEMETERY OR CREMATORY Calvary 23d. LOCATION (City, town, or county) (State) St. Louis Missouri

24. FUNERAL DIRECTOR ST. LOUIS FUNERAL HOME ADDRESS 2205 St. Louis Ave. 25. DATE RECD. BY LOCAL REG. JAN 27 59 26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. L.*

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.