

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019030

STATE FILE NUMBER

2-3823

FILED JUN 1 1959 Registration District No. Primary Registration District No. Registration No.

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1-57
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20

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON. TYPEWRITE IF POSSIBLE.

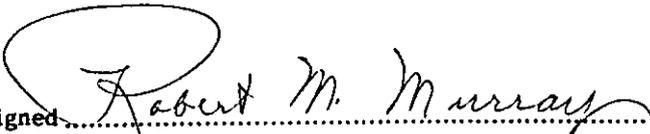
1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
0 St. Louis Children's		1hr 55min		none			
3. NAME OF DECEASED (Type or print)				First Middle Last		4. DATE OF DEATH Month Day Year	
Crystal Lee Cavitt						April 16, 1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female	White			4/16/59		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins. 15 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?	
none		none		Troy, Missouri		USA	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
William Robert Cavitt			Martha Lou Davis			Never Married	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
none			none		EMorsech-500 S.Kingshighway Blvd.		
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>INTRACRANIAL HEMORRHAGE</u>							INTERVAL BETWEEN ONSET AND DEATH 15 HR 510 MIN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>BIRTH TRAUMA</u>							
DUE TO (c) <u>760.5</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PREMATURE INFANT - SEVERE PULMONARY ATELECTASIS</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>4/16/59</u> to <u>4/16/59</u> and last saw her/him alive on <u>4/16/59</u> Death occurred at <u>5:55PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<u>Richard Hoppe, M.D.</u>				500 S. Kingshighway Blvd.		4/16/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal		4-19-59				Wright City, Mo.	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Albert H. Hoppe, 4700 Washington Blvd.				APR 17 '59		<u>Richard Smith, M.D.</u>	

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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 

Licensed Embalmer No. 3749
P. O. Address St Louis Mo

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.