

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 18 1960

-60-014235

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 431 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>3 hrs.</b>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3140 Hawthorne Dr.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Baby Eoy</b> Middle <b>(Unnamed)</b> Last <b>Cavender</b>	4. DATE OF DEATH Month <b>April</b> Day <b>1</b> , Year <b>1960</b>
-----------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 31, 1960</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>3</b> Min. <b>40</b>
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------	------------------------------------	--------------------------------------------------	-------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--------------------------------------------------------------------------------------------------------------	----------------------------------------------------	---------------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <b>Litton Elmo Cavender</b>	13b. MOTHER'S MAIDEN NAME <b>Barbara Ann Ogden</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
---------------------------------------------------	-------------------------------------------------------	--------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Litton Elmo Cavender, St. Joseph, Mo.</b>	Address
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	---------------------------------------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Multiple Congenital defects</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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>St. Joseph, Mo.</b>	COUNTY <b>Buchanan</b>	STATE <b>Missouri</b>
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------------	---------------------------	--------------------------

21. I attended the deceased from **3-31-60** to **4-1-60** and last saw **him** alive on **4-1-60**  
Death occurred at **12:15** **A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Decease or first) <i>J. Mothershead</i>	22b. ADDRESS <b>2603 Friedrich</b>	22c. DATE SIGNED <b>4-7-60</b>
------------------------------------------------------------	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>April 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D.W. Newcomers Sons</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
---------------------------------------------------------------	-----------------------------------	------------------------------------------------------------------	-------------------------------------------------------------------------------

24. FUNERAL DIRECTOR <i>Mrs. Clark Stoddell</i>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>April 9, 1960</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Stoddell</i>
----------------------------------------------------	-----------------------------------	------------------------------------------------------	---------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF J.L. Mothershead, M.D. CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Eric J. Pham*

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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.