

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039462
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3044

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY COLE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MISSOURI		c. CITY OR TOWN JEFFERSON CITY	
Length of stay in 1b 16 DAYS		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 821 EAST ELM	
Inside Limits <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last CAVE			4. DATE OF DEATH OCTOBER 29, 1961 Month Day Year				
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-12-98	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) BLOOMFIELD, MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WESLEY CAVE			13b. MOTHER'S MAIDEN NAME BETTY CASON		14. NAME OF HUSBAND OR WIFE ETHEL REYNOLDS CAVE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II			17. INFORMANT Address ETHEL REYNOLDS CAVE (WIFE) 414 AGRICULTURAL, MEXICO, MO.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA			3 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			4 WEEKS	
DUE TO (b) INTESTINAL OBSTRUCTION			6 MOS	
DUE TO (c) CARCINOMA OF TRANSVERSE COLON				

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 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 a.m. p.m.	Month, Day, Year				
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 10-13-61 to 10-29-61
Death occurred at 3:25 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Gene Nichols</i> GENE NICHOLS, M.D.	(Degree or title)	22b. ADDRESS VET ADM HOSP, JEFF BRKS, MO.	22c. DATE SIGNED 10-29-61
---	-------------------	--	------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE 10-31-61	23c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery	23d. LOCATION (City, town, or county) Tebbetts, Mo.
--	-----------------------	---	--

24. FUNERAL DIRECTOR Claypool Funeral Home, New Bloomfield, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 10-30-61	REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>
--	---------	--	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

NOV 17 1961

NOV 18 1961 SA

NOV 19 1961

NOV 22 1961

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 Robert M Murray

Licensed Embalmer No. 37490

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.