

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045656

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11611

FILED DEC - 2 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED
1	
2	217
3	2
4	1
5	1
6	
7	1
8	2
9	
10	
11	
12	76-D
13	
76	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b OR TOWN		c. CITY OR TOWN		Inside Limits			
		St. Louis,		8-4-60 11-23-63		St. Louis,		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS		(If outside, give location) Reside on Farm			
St. Louis Chronic Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		4000 Flora Place		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Cecelia			Ellen		Kavanagh		Kavanaugh		November 23, 1963		
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Female		White				11-22-1878		85			
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			
housewife				own home		Montgomery Indiana		U.S.A.			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
Michael Buckley				Mary Jane Buckley				Patrick Kavanaugh (DEC)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)						17. INFORMANT Address					
NO						Mr. Robert Patrick Kavanaugh 6300 Hancock					
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)											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b)											
DUE TO (c)										4200	
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 checked="" 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						Aug. 4, 1960		to		Nov. 23, 1963	
Death occurred at						3:50 A.M.		m on the date stated above, and to the best of my knowledge, from the causes stated.		and last seen her alive on	
22a. SIGNATURE						(Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
[Signature]								5800 Arsenal		11-23-63	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
Removal		11-27-63		National Cemetery		St. Louis County, Mo.					
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
HOFFMEISTER COLONIAL MORTUARY				SAW		NOV 25 1963		Leon Smith, M.D.			

6464 Chippewa

(Licensed Embalmer's Statement on Reverse Side)

888 8 - 888 018 888

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 John J. Denny

Licensed Embalmer No. 4194
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.