

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27575
Registrar's No. 3233

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4921 Walnut
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community: 79 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Miss Johanna Cavanaugh

3. (b) If veteran, name war

No

3. (c) Social Security No.

None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: August 18, 1862
(Month) (Day) (Year)

8. AGE:

Years 79

Months 0

Days 9

If less than one day

hr. _____ min. _____

9. Birthplace: Rolla, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business _____

MOTHER FATHER

12. Name: Joseph Cavanaugh

13. Birthplace: Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name: Catherine O'Donnell

15. Birthplace: Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. John J. Cavanaugh

(b) Address: 4921 Walnut

17. (a) Burial (b) Date thereof: 8-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. St. Mary's Cem

18. (a) Signature of funeral director: John W. Wagner
Kansas City, Missouri

(b) Address: 9/28/41 M. M. Cronin

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 042
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 4921 Walnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27th
year 1941 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 25, 1941
_____ 19____ to _____ 19____;
that I last saw h.e.v. alive on Aug 25 _____ 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic heart disease

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature: J. H. Hoffmann M.D. (M. D. or other) D
Address: 408 Argyle Bldg Date signed: 9/29/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

G. J. Hoffmann M.D.
11:30 to 4
1

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Cecil R. Matthes*
Licensed Embalmer No. *3807*
P. O. Address *Kansas City, 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 this body is not embalmed, fact should be so stated above.