

FILED NOV 21 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 85137

Registration District No. 384

Primary Registration District No. 5535

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Rural - Howell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Rt. 1, West Plains  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Six weeks / (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 046  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rt. 1, West Plains, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27  
year 1941 hour 4 minute 30 A. M.  
21. I hereby certify that I attended the deceased from Sept. 10-10th  
Sept 10-11 1941 to Sept 10- 1941  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Hypertension Duration \_\_\_\_\_  
Due to Senility  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_ 938  
Of autopsy \_\_\_\_\_  
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?

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M.D. or D.V.M.)  
Address [Address] Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Kate Cavender

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fem 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife T. J. Cavender 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 7 1852  
(Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Clay County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name \_\_\_\_\_ Carroll  
13. Birthplace \_\_\_\_\_ Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace \_\_\_\_\_ Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E. M. Wilhoit  
(b) Address Rt. 1, West Plains, Mo.

17. (a) Burial (b) Date thereof 9-28/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holt Cem. + Clay Co., Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address West Plains, Mo.

19. (a) 10-27-41 (b) Vida W SIMMONS  
(Date received local registrar) (Registrar's signature)

377

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

4600

RECEIVED

Sanitary Health Officer No. 5,

District File Number 11412068

Date Filed \_\_\_\_\_

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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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**