

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39009**  
Registrar's No. **10830**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(c) Name of hospital or institution 3060 Bayard Ave.  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3060 Bayard Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNIE CAVANAUGH  
3. (b) If veteran, name war None 3. (c) Social Security No. None  
4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 30, 1871  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 11  
year 1945 hour 10: 35 minute P. M.  
21. I hereby certify that I attended the deceased from 4 Dec 1945 to 11 Dec 1945  
that I last saw her alive on 10 Dec 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Coronary Thrombosis Duration 30 MIN  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) None  
Major findings: None  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day  
74 0 11 hr. min.  
9. Birthplace St. Louis Mo.  
(City, town or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Thomas Cavanaugh  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Ann Kennedy  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
16. (a) Informant Helen Cavanaugh  
(b) Address 3060 Bayard Ave.  
17. (a) Buried (b) Date thereof 14, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gallop  
18. (a) Signature of funeral director J. J. Quinn  
(b) Address 1389 Chestnut St.  
19. (a) DEC 13 1945 (b) J. J. Quinn  
(Date received local registrar) (Registrar's signature)

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. J. Quinn (M. D. or other) MD  
Address 1014 Stella St. Date signed 12 Dec 45

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

03  
17  
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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.....

*John Ketter*

Licensed Embalmer No. *3880*

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 this body is not embalmed, fact should be so stated above.**