

No. 2  
12-45  
5-17-39  
K47070

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

FILED SEP 15 1947

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 711 E

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
404 W. Division St. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 59 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 404 W. Division  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Roy A. Cavin

3. (b) If veteran, name war World War I

3. (c) Social Security No. 49-03-0539

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Cora Cavin

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased October 27 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

59	10	2	hr. min.
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9. Birthplace Dallas County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Funeral Director & Embalmer

11. Industry or business " " "

MOTHER FATHER { 12. Name Joseph M. Cavin

13. Birthplace Missouri Missouri  
(City, town or county) (State or foreign country)

14. Maiden name Mary Wood

15. Birthplace Missouri Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Cavin

(b) Address 404 W. Division

17. (a) Burial (b) Date thereof 8-11-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director J.W. Klingner & Co.

(b) Address Springfield, Missouri

19. (a) 8-11-47 (b) W. H. Handley M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9  
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 16 to August 9, 1947  
that I last saw him alive on August 9, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Portal Obstruction Duration 5 mo.

Due to Carcinomatosis with metastasis in the liver 9 mo.

Due to Carcinoma of the cecum 12 mo.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 46 E

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) (e) Means of injury 0

23. Signature P. M. Klingner (M. D. or other) M.D.  
Address 1511 E. Commercial Date signed 8-11-47

SEP 19 1947

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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 *Max Rhodes*  
.....  
Licensed Embalmer No. *4071*  
.....  
P. O. Address *Springfield.*  
.....

**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.**