

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41348**
11021
Registrar's No. _____

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5249 Nagel /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **50 Years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5249 Nagel**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

August Cavin

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Rosie** 6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **April 20 1868**
(Month) (Day) (Year)

8. AGE: Years **80** Months **7** Days **28** If less than one day _____ hr. _____ min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Inspector**

11. Industry or business _____

12. Name **Cavin**
13. Birthplace **Switzerland**
(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 **Rosie Cavin**

(b) Address **5249 Nagel**

17. (a) **Burial** (b) Date thereof **12/21/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St Marcus Cem.**

18. (a) Signature of funeral director **J.L. Ziegenhein & Sons**

(b) Address **7027 Gravois**

19. (a) **DEC 21 1948** (b) **J. B. Lasater**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **18**,
year **1948** hour **11** minute **00** A.M.

21. I hereby certify that I attended the deceased from **Dec 15** 19**48** to **Dec 18** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coraue Distention**
Due to **Chronic Myocarditis**
Duration _____

Other conditions **Arterio Sclerosis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN **[Signature]**
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? _____ (c) Means of injury **[Signature]**

23. Signature **[Signature]** (M. D. or other) _____
Address **[Signature]** Date signed **12/21/48**

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

MOTHER FATHER

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7027 Gravois

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.