S. No. 300
V. 10.48

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

FILED APR 10 1950

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

10266

State File No. 3165

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Saint Louis
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Firmin Desloge Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Saint Louis
d. STREET ADDRESS (If rural, give location): 5738 Labadie

**3. NAME OF DECEASED** (Type or Print): a. (First) Lucille b. (Middle) c. (Last) Cavanaugh

**4. DATE OF DEATH** (Month) 3 (Day) 31 (Year) 50

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH:** July 1, 1913

**9. AGE** (In years last birthday): 36 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Missouri

**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13a. FATHER'S NAME:** Dunsworth, Alvin

**13b. MOTHER'S MAIDEN NAME:** Jordan, Nellie

**14. NAME OF HUSBAND OR WIFE:** Vincent Cavanaugh

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT'S SIGNATURE OR NAME:** Vincent Cavanaugh — **ADDRESS:** 5738 Labadie

**18. CAUSE OF DEATH**
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Chron.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Brain abscess — 3 wks
Bacterial Endocarditis
β Hemolytic Streptococcus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** YES ☐ NO ☒

**21a. ACCIDENT SUICIDE HOMICIDE** (Specify)

**21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.)

**21c.** (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 0538

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.

**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**21f. HOW DID INJURY OCCUR?**

**22.** *I hereby certify that I attended the deceased from* March 25, 19 50, *to* March 31, 19 50, *that I last saw the deceased alive on* March 31, 19 50 *and that death occurred at* 3:16a. *m., from the causes and on the date stated above.*

**23a. SIGNATURE:** M. L. Gochausen M.D. (Degree or title)

**23b. ADDRESS:** 1325 South Grand Avenue

**23c. DATE SIGNED:** 3-31-50

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**24b. DATE:** 4-3-50

**24c. NAME OF CEMETERY OR CREMATORY:** Calvary

**24d. LOCATION** (City, town, or county) (State): St. Louis Mo.

**DATE REC'D BY LOCAL REG.:** APR 1 1950

**REGISTRAR'S SIGNATURE:** J. B. Sarsaten

**25. FUNERAL DIRECTOR'S SIGNATURE:** Chas. F. Stuart — **ADDRESS:** 1225 Union

(Licensed Embalmer's Statement on Reverse Side)

## 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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Clement McNeary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.