

V. S. No. 7
AM-11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8443**
Registrar's No. **68**

FILED MAR 17 1941
Registration District No. **275**

Primary Registration District No. **3039**

108
1
2

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

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nevada City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days) 20 yrs.

3. (a) PRINT FULL NAME Ida May Cassady
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F. 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 May 2 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
12. Name Martin Owen Southwell
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Mary Landfield
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Vivian Cassady
(b) Address Nevada Mo.

17. (a) Burial (b) Date thereof Feb. 9 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calixie Cemetery

18. (a) Signature of funeral director Allen V. Hays
(b) Address Nevada Mo.

19. (a) 2-8-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Vernon
(c) City or town Nevada
(If outside city or town limits, write "RURAL")
(d) Street No. 220 W. Allison
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9 year 1941 hour 2:20 minute _____ A.M.
21. I hereby certify that I attended the deceased from Jan 31, 1941 to Feb 9, 1941; that I last saw her alive on Feb 8, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardio-vascular renal disease
Due to _____
Due to _____
Other conditions Yellowed face
(Include pregnancy within 3 months of death)

Duration 5 yrs

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: Of operations none
Of autopsy none

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? Yes
Whereat work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Allen V. Hays (M. D. or other)
Address Nevada Mo. Date signed 2-11-41

186
99

RECEIVED

District Health Officer No. 7,

District File Number 3-41-465

Date Filed 3-7-41

54712

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 Allen V. Hoar

Licensed Embalmer No. 1968

P. O. Address Nevada 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8443

Registration District No. 875-

Primary Registration District No. 2039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Neuada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Ida May Cassady
3. (b) If veteran. name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8 year 1941 hour 2:30 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 1941 to _____ 1941.
that I last saw her alive on Feb 7, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular renal dispa... Duration _____

Due to _____ 17 W

Other conditions Falling due to
(Include pregnancy within 3 months of death)
depression, not cause of death

Major findings contributory to death PHYSICIAN
Of operations _____
Of autopsy _____
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 _____

23. Signature [Signature] (M. D. or other) _____
Address Neuada Mo Date signed 5-9-41

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

SUPPLEMENTAL

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.