S. No. 2
M—9-4-41
V. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7974

FILED MAR 20 1942

Registration District No. 1926

Primary Registration District No. 605-1-11485

Registrar's No.

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queencity MO

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

(c) Name of hospital or institution: none!

(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)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Schuyler

(c) City or town Queencity

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

(d) Street No. Rural

(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Austin L. Cass

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of ~~husband~~ or wife Effie

6. (c) Age ~~of husband or~~ wife if alive 66 years

7. Birth date of deceased Feb (Month) 8 (Day) 1868 (Year)

8. AGE: Years 73 Months 11 Days 28 If less than one day hr. min.

9. Birthplace Near Queencity (City, town, or county) MO (State or foreign country)

10. Usual occupation farming

11. Industry or business None

FATHER

12. Name Calvin Cass

13. Birthplace Not Known (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Fanny Capps

15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant B. L. Cass

(b) Address Chicago Ill

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Tarr Cemetery

18. (a) Signature of funeral director Wm M Webb

(b) Address Queencity MO

19. (a) 2/8-1942 (Date received local registrar) (b) Oliver B Jones Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6 year 1942 hour 12 minute 5 P.M.

21. I hereby certify that I attended the deceased from Feb 6, 1942 to Feb 6, 1942 that I last saw h~~im~~ alive on Feb 6, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Indigestion	
Due to: Gas in digestive tract Pressure	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. P. Green (M. D. or other) D.O.

Address Queencity Mo Date signed Feb 8

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-278
Date Filed MAR 9 1942

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 Self, Registered Apprentice No. , working under my personal supervision.

Signed Wm. H. West

Licensed Embalmer No. 2882

P. O. Address Queencity 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.