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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 9 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35081

State File No.

Registration District No. 774 Primary Registration District No. 3035 Registrar's No. 71

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: 2123 South
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 51 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

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

(d) Street No. 2123 South
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME BON CARROLL CASNER

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Ma

5. Color or race W

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 Aug (Month) 5 (Day) 1872 (Year)

8. AGE: Years 71 Months 2 Days 3 If less than one day hr. min.

9. Birthplace Carroll Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation farmer

11. Industry or business retired

FATHER
12. Name Henry S. Casner
13. Birthplace Carroll Co. (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Mary Eliz Key
15. Birthplace Carroll Co. (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs. Wm Crowe
(b) Address Lexington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-43 (Month) (Day) (Year)
(c) Place: burial or cremation Dover, Mo

18. (a) Signature of funeral director Winkler
(b) Address Lexington, Mo

19. (a) Nov-4-43 (Date received local registrar) (b) Mrs. F. Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8
year 1943 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from ..., 194 to Oct 1st, 1943
that I last saw him alive on Oct 9, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Recurrent Hemiplegia	18 mo
Due to Cerebral hemorrhage	Sudden
Due to Arteriosclerosis + hypertension	
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. R. Ryland (M. D. ~~or other~~)
Address Lexington Mo Date signed 10/13/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number
Date Filed 11-6-43

Ryland

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 Forrest F. Tempel

Licensed Embalmer No. 3275

P. O. Address Lexington, 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.