S. No. 2
I—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14491

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 362

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Desloge Rondo

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

(c) Name of hospital or institution: 606 South Main 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community 4 Years

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Francois

(c) City or town Desloge 94

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

(d) Street No. 0

(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Cassie Elizabeth Nelms

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

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased March (Month) 28 (Day) 1868 (Year)

8. AGE: Years 76 Months 10 Days 23 If less than one day ..... hr. ..... min.

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

10. Usual occupation House wife

11. Industry or business .....

FATHER
12. Name John Dunnigan
13. Birthplace Tennessee 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Louise Pyles
15. Birthplace Reynolds Co. Mo. D (City, town, or county) (State or foreign country)

16. (a) Informant Chas. G. Nelms

(b) Address Desloge Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Park View

18. (a) Signature of funeral director C. Z. Boyer

(b) Address Desloge Mo

19. (a) 3-30-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1945 hour 4 minute 8 P.M.

21. I hereby certify that I attended the deceased from Aug. 8 1944, to Feb. 20 1945 that I last saw her alive on Feb. 20 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac hypertrophy & dilatation	1 yr
Due to Senility	—
Due to	
Other conditions General Chronic Passive Congestion (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy 95 c 3

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 [signature] (M. D. or other)

Address Flat River Mo. Date signed 3-7-45

1373

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 445-517

Date Filed 4-17-45

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 C. Z. Bayer

Licensed Embalmer No. 1671

P. O. Address Desloge Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 362

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Desloge Randolph Twp
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Cassie E. Nelson
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 (W)
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Mar (Month) (Day) (Year)
8. AGE: Years 76 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 20 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

14491