

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FRED JUL 11 1945

Registration District No. 2/1Primary Registration District No. 3012Registrar's No. 86

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Excelsior Springs Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Weeks
 In this community 30 Years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME ELIZABETH JANE CASS

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 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 July 14 1865
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 11 9 hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Stuart Mann

13. Birthplace Scotland
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Lou Cass

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof 6/25/1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Springs, Mo.

18. (a) Signature of funeral director Claude Richard

(b) Address Excelsior Springs, Mo.

19. (a) 6-25-45 (b) Mrs Sadie Redman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23rd.
 year 1945 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from 6/6/45
 _____, 19____, to 6/23/45, 19____
 that I last saw her alive on 6-22/45, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, uterus + Intestine
2 yr
Balance

Due to _____

Due to _____

Other conditions 0
 (Include pregnancy within 3 months of death)

Major findings: 0

Of operations 0

Of autopsy 0

Duration

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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0
 (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) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) 710

Address Excelsior Spg Date signed 6/27/45

RECEIVED

District Health Officer No. 8,

File Number _____

Date Filed 7/19/68

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 _____
E. O. White

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs

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.