No. 2
—8-13
-17-39
X37823

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. 24433

FILED JUL 16 1945

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. 69

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution:
Still-Hildreth Sanatorium O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 mos. 16 days (Specify whether
In this community years, months or days)

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 Lila Cassidy

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F. 1

5. Color or race W

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

6. (b) Name of husband or wife Noan Cassidy

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

7. Birth date of deceased June (Month) 7 (Day) 1894 (Year)

8. AGE: Years 51 Months 0 Days 6 If less than one day 7 hr. 10 min.

9. Birthplace Hutchinson (City, town, or county) Kans. 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lorenzo Whinery
13. Birthplace (City, town, or county) Ohio 1 (State or foreign country)

MOTHER
14. Maiden name Priscilla McNilsan
15. Birthplace (City, town, or county) Don't Know 0 (State or foreign country)

16. (a) Informant Joan Cassidy
(b) Address Rossville Kans.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 15, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Patridge Kans.

18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo

19. (a) 7/3/45 (Date received local registrar) (b) Nora B. Hunkler (Registrar's signature)

1031

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1945 hour 7 minute 10 A.M.

21. I hereby certify that I attended the deceased from July 27, 1944 to June 13, 1945; that I last saw her alive on June 13, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Embolis	
Due to Cerebral Hemorrhage	
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 Robert B. Cross (M.D. or other) D.O.

Address Macon, Missouri Date signed June 13, 1945

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1103
Date Filed JUL 13 1945

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 Albert Skinner, Registered Apprentice No. 751, working under my personal supervision.

Signed Albert Skinner

Licensed Embalmer No. 751

P. O. Address Macon Mi

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.

No. 2B
—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. 69

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution: Still-Hildreth Sanatorium (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Shawnee

(c) City or town Rossville (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 Lila Cassidy

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 M

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

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

7. Birth date of deceased June (Month) 7 (Day) 1845 (Year)

8. AGE: Years 51 Months 0 Days 6 If less than one day ..... hr. 10 min.

9. Birthplace ..... (City, town, or county) Kans (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) 7/19/45 (Date received local registrar) (b) Nora B Hunkler (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 7 year 1945 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.

	Duration
Immediate cause of death	
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

S-24433