

S. No. 2
M-5-43
5-17-39
X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 648

FILED FEB 14 1947
Registration District No. 170

Primary Registration District No. 5349

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County DALLAS
(b) City or town WINDYVILLE
(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)
In this community ALWAYS (Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES FRANK CANSLER
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife LUCY CANSLER
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAR 22 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 11
If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER
12. Name ELIHA CANSLER
13. Birthplace NY
(City, town, or county) (State or foreign country)
14. Maiden name LAVICIA FIELD
15. Birthplace IND.
(City, town, or county) (State or foreign country)

16. (a) Informant Home Group
(b) Address WINDYVILLE MO

17. (a) BURIAL (b) Date thereof 2-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CROSS ROADS

18. (a) Signature of funeral director PALMER S.
(b) Address LEDANON MO

19. (a) 3-23-47 (b) Shore Petree
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County DALLAS
(c) City or town WINDYVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 3
year 1947 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from ON
Dec 30 1946
that I last saw him alive on Dec 30 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia due to Chronic Bronchitis
Due to Chronic Bronchitis
Due to OK

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None

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? _____

While at work? _____ Means of injury _____
23. Signature W. H. Plummer (M. D. or other) MI
Address Buffalo MO Date signed 2-6-47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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..... *W. Bohner*

Licensed Embalmer No. *1161*

P.O. Address *Leland, Wis.*

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.

Registration District No. 76 Primary Registration District No. 5349

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Windsorville
(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
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

James F. Casler

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased mar 22
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days _____ Unless than one day
hr. _____ m.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-23-47 (b) Gene P. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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 6 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

