No. 300
10.48

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

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14873

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 499

1. PLACE OF DEATH
a. COUNTY: BUCHANAN
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. JOSEPH
c. LENGTH OF STAY (In this place): 5 HOURS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST JOSEPH HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: MISSOURI
b. COUNTY: HOLT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): FOREST CITY
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ANSON
b. (Middle): BURR
c. (Last): CASS

4. DATE OF DEATH (Month) MAY (Day) 1 (Year) 1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG. 16, 1871
9. AGE (In years last birthday): 77 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): FOREST CITY, MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: MARTIN V. CASS
13b. MOTHER'S MAIDEN NAME: ELIZABETH VANGLIDER
14. NAME OF HUSBAND OR WIFE: DRUSILLA CASS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: NELSON CASS — ADDRESS: FOREST CITY, MISSOURI

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 30, 1949, *to* May 1, 1949, *that I last saw the deceased alive on* 4/30, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. F. Turner MD
23b. ADDRESS: Oregon Mo.
23c. DATE SIGNED: 5/2/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May 3, 1949
24c. NAME OF CEMETERY OR CREMATORY: FOREST CITY
24d. LOCATION (City, town, or county) (State): FOREST CITY Mo

DATE REC'D BY LOCAL REG.: May 2, 1949
REGISTRAR'S SIGNATURE: E. E. Jenkins 382
25. FUNERAL DIRECTOR'S SIGNATURE: James K Pretzjohn — **ADDRESS**: Oregon Mo

(Licensed Embalmer's Statement on Reverse Side)

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed James L. Pettijohn

Licensed Embalmer No. 3192

P. O. Address Oregon Mo.

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

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