

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16240**

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **158**

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 2650 Stark Kansas City Mo.	
c. LENGTH OF STAY (in this place) 12 yrs		d. STREET ADDRESS (If rural, give location) 2650 Stark Rural (Blue)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitarium			

3. NAME OF DECEASED (Type or Print) Iva Nell Cassill			4. DATE OF DEATH (Month) (Day) (Year) May 22 1949		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 24 1889		9. AGE (In years last birthday) 60	or UNDER 1 YEAR Months	or UNDER 1 YEAR Days	or UNDER 1 YEAR Hours	or UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME William Stouse		13b. MOTHER'S MAIDEN NAME Mattie Davis		14. NAME OF HUSBAND OR WIFE Charles H. Cassill	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Charles H Cassill		ADDRESS Kansas City Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis							
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4201	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Reputedly Coronary				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:45 AM**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 2800 Main		23c. DATE SIGNED 5/28/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 25 1949	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Missouri
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DATE REC'D BY LOCAL REG. May 23 1949	REGISTRAR'S SIGNATURE [Signature]	354	25. FUNERAL DIRECTOR'S SIGNATURE Mrs C.L. Gorster	ADDRESS # 918 Brooklyn
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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.

Signed.....
Student Embalmer

Signed *John Clark*
.....
Licensed Embalmer No. *4216*

P. O. Address *S. C. Me*

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.