

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39806

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>329</u>		
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (in this place) <u>18 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Stephens</u>		<u>0141</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) a. (First) <u>DAN</u>			b. (Middle) <u>MURRAY</u>		c. (Last) <u>CASON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22, 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married /</u>		8. DATE OF BIRTH <u>July 25, 1879</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Callaway County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Joseph Richmond Cason</u>			13b. MOTHER'S MAIDEN NAME <u>Lottie McKim</u>		14. NAME OF HUSBAND OR WIFE <u>Sally Ann Haden Cason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. George King, Columbia, Mo.</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension and arteriosclerosis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>4 years</u> <u>331X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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) m.		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 <u>12-4</u> , 19 <u>50</u> , to <u>12-22</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>12-22</u> , 19 <u>50</u> , and that death occurred at <u>3:55 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>James W. Allen M.D.</u>				23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>12-22-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 26, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u>			
DATE REC'D BY LOCAL REG. <u>Dec 23 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		31 <u>31</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker Funeral Service, Columbia, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 12-27-50

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed: 12-27-50

DEC 11 1950

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

*Paul L. Young*

Licensed Embalmer No.

4132

P. O. Address

Columbia, S.C.

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.