

FILED JAN 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3435

State File No.

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 3072		Registrar's No. 8	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall,		c. LENGTH OF STAY (in this place) 6 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall,		0972	
d. FULL NAME OF HOSPITAL OR INSTITUTION 326 North Sargent				d. STREET ADDRESS (If rural, give location) 326 North Sargent			
3. NAME OF DECEASED a. (First) Anna (Type or Print)			b. (Middle) Gertrude		c. (Last) Cason		4. DATE OF DEATH (Month) (Day) (Year) Jan. 15, 51
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 25, 1913	9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months 0	IF UNDER 1 YEAR Days 20	IF UNDER 1 MIN. Hours -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) Miami Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Eugene Carter			13b. MOTHER'S MAIDEN NAME Irene Gertrude Buckner		14. NAME OF HUSBAND OR WIFE William Cason		
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. none		17. INFORMANT'S SIGNATURE OR NAME William Cason, Marshall, Mo			ADDRESS
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Breast 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 Several weeks Don't know 170X
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 June 16 th , 1950, to Jan. 15 th , 1951, that I last saw the deceased alive on Jan. 15 th , 1951, and that death occurred at 12:35P.m., from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) Waite H. Madison, M.D.				23b. ADDRESS Marshall, Missouri		23c. DATE SIGNED 1-16-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/17/51	24c. NAME OF CEMETERY OR CREMATORY Miami Cemetery		24d. LOCATION (City, town, or county) (State) Miami, Missouri		
DATE REC'D BY LOCAL REG. Jan-17-1951		REGISTRAR'S SIGNATURE Sidney F. Gray		385		25. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Green & Sons	
						ADDRESS Marshall, Mo	

(Licensed Embalmer's Statement of Reverse Side)

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

RECEIVED 1-22-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 1-22-51

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 _____
working under my personal supervision.

Signed _____
Student Embalmer

Signed _____
Student Embalmer No. _____
Licensed Embalmer No. 4270
P. O. Address Marshall, Mo.

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.