

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

28132

State File No.

No. 300
10.48

FILED AUG 31 1953

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 96

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| 1. PLACE OF DEATH a. COUNTY <u>COOPER</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>MONITEAU</u> | |
| b. CITY OR TOWN <u>BOONVILLE MO</u> c. LENGTH OF STAY (in this place) <u>12 yr</u> | | c. CITY OR TOWN <u>RURAL LINN</u> <u>0680</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BOONVILLE HARRYING HOME</u> | | d. STREET ADDRESS (If rural, give location) <u>MARY JAMESTOWN MO</u> | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>-</u> c. (Last) <u>CASSIL</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 23-1953</u> | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | |
| 8. DATE OF BIRTH <u>June 6-1875</u> | | 9. AGE (In years last birthday) <u>78</u> | | 10. IF UNDER 1 YEAR Hours <u>2</u> Min. <u>14</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | |

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| 13a. FATHER'S NAME <u>PHILLIP CASSIL</u> | | 13b. MOTHER'S MAIDEN NAME <u>LOUISA PAYTEE</u> | | 14. NAME OF HUSBAND OR WIFE <u>ALICE CASSIL</u> | |
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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) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Eugene Cassil, Jamesstown Mo</u> ADDRESS _____ | |
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| 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) <u>Arterio Sclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| | | 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 <u>4500</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
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| 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) | |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
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22. I hereby certify that I attended the deceased from March 1953, to Aug 23, 1953 that I last saw the deceased alive on Aug 19, 1953, and that death occurred at 7:09 p.m., from the causes and on the date stated above.

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|--|--|----------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <u>M L DeGraaf M.D.</u> (Degree or title) | | 23b. ADDRESS <u>Boonville Mo</u> | | 23c. DATE SIGNED <u>8/27/53</u> | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>Aug 25-1953</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>CONCORD CEM.</u> | | 24d. LOCATION (City, town, or county) (State) <u>JAMESTOWN MO</u> | |
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| DATE REC'D BY LOCAL REG. <u>8-25-53</u> | | REGISTRAR'S SIGNATURE <u>W Hooper</u> <u>381</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>e. Albert Hombeck</u> ADDRESS <u>Brairie Home Mo.</u> | |
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(Licensed Embalmer's Statement on Reverse Side)

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

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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.

Student
Student Embalmer

Signed *C. Albert Hornbeck*

Licensed Embalmer No. *2714*

P. O. Address *Prairie Home, Ill.*

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.