

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **22538**No. 300  
10.48BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **93** PRIMARY REG. DIST. NO. **4153** Registrar's No. **54-47**

1. PLACE OF DEATH a. COUNTY <b>Dade</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Dade</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Loekwood Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>rural north twp</b>	
c. LENGTH OF STAY (in this place) <b>2wks</b>		d. STREET ADDRESS (If rural, give location) <b>4mi n. greenfield mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Memorial hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Raymond</b> b. (Middle) <b>Melvin</b> c. (Last) <b>Cason</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>july 9 1954</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>April 8, 1908</b>	9. AGE (in years last birthday) <b>46</b>	IF UNDER 1 YEAR <b>3</b> Months <b>1</b> Day
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>westinghouse</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>dorena mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Victor Cason</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Cason</b>		14. NAME OF HUSBAND OR WIFE <b>Ida Cason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>493-14-2869</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Ida Cason Greenfield Mo.</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of sigmoid</b>		
	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. <b>153 X</b>			

19a. DATE OF OPERATION <b>May 11 1954</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of sigmoid with metastases</b>		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 **11-27, 1953**, to **7-9-**, 19 **54**, that I last saw the deceased alive on **7-8**, 19 **54**, and that death occurred at **2:28a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Luce McNeely MD</b>		23b. ADDRESS <b>Greenfield Mo</b>	23c. DATE SIGNED <b>7-10-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 11, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenfield</b>	24d. LOCATION (City, town, or county) (State) <b>Greenfield Mo.</b>

DATE REC'D BY LOCAL REG. <b>7-11-54</b>	REGISTRAR'S SIGNATURE <b>J. C. Canada 478</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W.R. Allison Greenfield Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 21 1953

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 W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenville 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.