

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23116

State File No.

FILED AUG 15 1955

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 210

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	
c. LENGTH OF STAY (in this place) <u>56 mo</u>		d. STREET ADDRESS (If rural, give location) <u>514 So. Kentucky</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>514 So. Kentucky</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Albert</u> b. (Middle) <u>HENRY</u> c. (Last) <u>CASSING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 9 1955</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>Jan 29 1882</u>		9. AGE (In years last birthday) <u>73</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>		11. BIRTHPLACE (State or foreign country) <u>Concordia Mo</u>	

13a. FATHER'S NAME <u>Henry Cassing</u>		13b. MOTHER'S MAIDEN NAME <u>Heturg Dwyer</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel M. Cassing</u>	
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15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>495-36-7117</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. G. H. Cassing</u>	
(If yes, give war or dates of service)				ADDRESS <u>Sedalia</u>	

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) <u>Carcinoma of stomach</u>		DUE TO (b) _____				6 mo.	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>151X</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)	
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 Aug 2, 1955, to Aug 9, 1955, that I last saw the deceased alive on Aug 9, 1955, and that death occurred at 2 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John E. Ramsey M.D.</u> (Degree or title)		23b. ADDRESS <u>111 N. 4th Sedalia Mo</u>		23c. DATE SIGNED <u>8/11/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-12-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>	
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DATE REC'D BY LOCAL REG. <u>8-12-55</u>		REGISTRAR'S SIGNATURE <u>L. W. Cook, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Laughlin Bros</u>		ADDRESS <u>Sedalia</u>	
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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 K. P. M. Crary

Licensed Embalmer No. 3153

P. O. Address Sedalia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.