

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000658
STATE FILE NUMBER

FILED FEB 4 1959

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 5

300
1-57

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Clinton</u> | | 2. USUAL RESIDENCE (Where deceased lived. If in institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>CAMERON</u> 251 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> | | Length of stay in lb <u>60 YRS</u> | d. STREET ADDRESS (If outside, give location) <u>723 E. 3RD ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Cassius M. WARD.</u> | | | 4. DATE OF DEATH Month Day Year <u>Jan. 21-1959.</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 25-1876</u> |
| 9. AGE years (of birthday) <u>82</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) <u>FARMER Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING.</u> | 11. BIRTHPLACE (City and state or country) <u>Ohio</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Jesse WARD.</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Rebecca King.</u> | | 14. NAME OF HUSBAND OR WIFE <u>Boke Deceased.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>494-34-8919</u> | 17. INFORMANT <u>Mr. Cecil Schoff</u> Address <u>HAMILTON MO</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> | | | <u>9 years</u> |
| DUE TO (c) <u>arteriosclerotic Heart Disease</u> | | | <u>9 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4200</u> |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from <u>3-16-1920</u> to <u>1-21-59</u> and last saw her alive on <u>1-12-59</u> Death occurred at <u>9:30A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>St Wetherston M.D.</u> | | 22b. ADDRESS <u>Cameron Mo</u> | 22c. DATE SIGNED <u>1-27-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>Jan 24 59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>McDaniel Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>CAMERON MO.</u> |
| 24. FUNERAL DIRECTOR <u>DeMoss CRUNK</u> | | ADDRESS <u>CAMERON MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>1-29-59</u> |
| | | 26. REGISTRAR'S SIGNATURE <u>Francis D Crawford.</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FEB 25 1959

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
Signature of Student Embalmer

Signed *W. Messerschmidt*

Licensed Embalmer No. *2533*

P. O. Address *Cameron, N.J.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.