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APR 23 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

7908

1. PLACE OF DEATH
County Callaway — Registration District No. 104 — File No.
Township — Primary Registration District No. 3008 — Registered No. 49
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME Earl McCasland
(a) Residence. No. State Hosp St., Hosp Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: about 50 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Dont Know

9. BIRTHPLACE (CITY OR TOWN) — (STATE OR COUNTRY) Dont Know

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) — (STATE OR COUNTRY) Dont Know
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) — (STATE OR COUNTRY) Dont Know

14. INFORMANT Hosp records
(Address) Fulton

15. FILED 2-3, 1930 R. N. Crews REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930 to Mar 3, 1930 that I last saw him alive on Mar 3, 1930, and that death occurred, on the date stated above, at 1 10 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A
97 (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (SECONDARY) arterio sclerosis
(duration) 1 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Fulton
IF NOT AT PLACE OF DEATH —
9 DID AN OPERATION PRECEDE DEATH? — DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) D. G. Irvine, M. D.
3-3, 1930 (Address) State Hosp. Fulton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Kirksville Mo — DATE OF BURIAL: Dont Know 19

20. UNDERTAKER: Hendon Taylor — ADDRESS: Fulton Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.