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

Do not use this space.

MAR 1 4 1935

1. PLACE OF DEATH
County: Audrain
Township: Cuivre
City: ..... (No. ..... St. ..... Ward)

Registration District No. 921
Primary Registration District No. 6232

File No. 4274
Registered No. .....

2. FULL NAME: Sarah E. Cassiday

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF W. P. Cassiday

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 3-1855

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
79	6	13	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own home
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER
13. NAME John Roberts
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Not obtainable
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know

17. INFORMANT J. B. Cassiday
(ADDRESS) Farber Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Farber Mo. DATE Feb. 18-1935, 19

19. UNDERTAKER W. S. Waters
(ADDRESS) Vandalia Mo.

20. FILED Mar. 19, 1935 W. A. May
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 16-1935, 19

22. I HEREBY CERTIFY, That I attended deceased from June. 24, 1934 to Jan. 16, 1935
I last saw him alive on Feb. 13, 1935 Death is said to have occurred on the date stated above, at 12.45 m. A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Asthma	Dont know

95 hrs

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....
(Signed) W. K. McCall, M. D.
(Address) Laddonia 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.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

100M-11-24-33