Form DEC 6 MAR 15 1939

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

8101
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon
(b) Township Washington
(c) City Nevada
(d) Street No. State Hosp. # 3 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 43 yrs. 2 mos. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 875
Primary Registration District No. 6162
Registered No. 44

2. PRINT FULL NAME Anna Cassell Anne Cassell McCoy
(a) Residence, No. State Hosp #3 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

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

7. AGE 83 YEARS — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. —
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) Unknown

FATHER
13. NAME Daniel Cassell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Maria Yager
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hosp. History State Hospital # 3

18. BURIAL, CREMATION, OR REMOVAL
PLACE Forest Park, Ill. DATE Feb. 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ferry Funeral Home Nevada, Mo

20. FILED 2-17, 1939 Allen V. Hays
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20, 1939

22. I HEREBY CERTIFY That I attended deceased from Mar. 1, 1938 to Jan 20, 1939
I last saw her alive on 1-20, 1939 Death is said to have occurred on the date stated above, at 1230 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocardial Degeneration	Old
Auricular Fibrillation	1-17-39

Other contributory causes of importance:
Senility 93 C

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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) Trip Shelton, M. D.
(Address) State Hosp #3

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No.
District File Number 7-39-3
Date Filed 3-8-39

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, Personall
....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Lloyd R Winscott

Licensed Embalmer No. 3857

P. O. Address Nevada, Mo

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

If this body is not embalmed, above space should be left blank.