59

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.

REC'D MAY 22 1939

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

15421
Do not use this space.

1. PLACE OF DEATH
(a) County Livingston Registration District No. 508
(b) Township or City Chillicothe Primary Registration District No. 3026 Registered No. 69
(c) (d) Street No. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Anna Casey
(a) Residence, No. 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Casey
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-22-1864
7. AGE YEARS 75 MONTHS 0 DAYS 4 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
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) Kendle Co Ill.

FATHER
13. NAME Michael Kays
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

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

17. INFORMANT (ADDRESS) John Casey Chillicothe Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic DATE April-29, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) James P. Gordon Chillicothe Mo
20. FILED 4-29- 1939 Donald O. Dowell Ohio 451
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April-26-, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1939, to Apr-26-, 1939
I last saw her alive on Apr-26-, 1939. Death is said to have occurred on the date stated above, at 10 P. m.
The principal cause of death and related causes of importance were as follows:

Carcinoma Uterus

Date of onset

48

Other contributory causes of importance:

Name of operation None Date of
What test confirmed diagnosis? Physical 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) Reuben Barney, M. D.
(Address) Chillicothe Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 39-504
Date Filed MAY 11 1939

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 James D Gordon, Registered Apprentice No. ..... working under my personal supervision.

Signed James D Gordon

Licensed Embalmer No. 1870

P. O. Address Lebellicoth M

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

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