

WED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24983**

Registration District No. **218**

Primary Registration District No. **3015**

Registrar's No. **63**

1. PLACE OF DEATH:

(a) County **Casper**
(b) City or town **Boonville, Mo**
(c) Name of hospital or institution: **St Josephs Hospital**
(d) Length of stay: In hospital or institution **4 days**
In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Morgan Co.**
(c) City or town **Gravois Mills**
(d) Street No. **R.F.D.**

3. (a) PRINT FULL NAME **Mrs William Caywood**

8. (b) If veteran, name war. **_____** 3. Social Security No. **_____**

4. Sex **Female** 5. Color or race **White**

6. (b) Name of husband or wife **Caywood** 6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **JAN 10 1891**

8. AGE: Years **49** Months **6** Days **23** If less than one day hr. min.

9. Birthplace **Gravois Mills Mo.**

10. Usual occupation **House wife**

11. Industry or business **" "**

12. Name **John B. Rastorfer**

13. Birthplace **Germany**

14. Maiden name **Mary Ann Kelly**

15. Birthplace **Penn.**

16. (a) Informant **Mr. William Caywood**

17. (a) **Burial** (b) Date thereof **July 6-1940**

18. (c) Signature of funeral director **W. F. Kidwell**

19. (a) **7-6-40** (b) **Boonville**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **3** year **40** hour **10** minute **03 P.M.**

21. I hereby certify that I attended the deceased from **6-20-40** to **7-3-40** that I last saw her alive on **7-3-40** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Vascular Nephritis**

Other conditions **Hypertension**

Major findings: Of operations **None** Of autopsy **None**

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) _____ (b) Date of occurrence _____ (c) Where did injury occur? _____ (d) Did injury occur in or about home, on farm, in industrial place, in public place? **107**

(e) Means of injury _____

28. Signature **Clara Ravenshaw** Address **Boonville Mo** Date signed **8-4-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

7
2
2

122

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-8-40

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.....

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

Signed Gene Barton
Licensed Embalmer No. 4021
P. O. Address Versailles, mo

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **218**

Primary Registration District No. **3015**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Cooper**
(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Mrs. Wanda Bell Caswood

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **49** Months **6** Days **23** If less than one year _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **3**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **uremia**

vascular nephritis

Hypertension

Due to **vascular nephritis-chronic**

(8-31-40 supplemental report)

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____ **131**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **Wanda Caswood** (Type of place)
Address **Boonville** (e) Means of injury _____
Boonville (D. O. or Other) _____

SUPPLEMENTAL REPORT

