

FILED DEC 14 1940 147

Primary Registration District No. 5810

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cass  
(b) ~~City or town~~ Rural Austin  
(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 All Life  
years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cass  
(c) City or town Rural Austin  
(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 Isabella McCaslin  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11  
year 1940 hour 8 minute 46 AM.  
21. I hereby certify that I attended the deceased from Nov 11  
1940 to Nov 11 1940  
that I last saw her alive on Nov 11 1940  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife John McCaslin 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb. 28 1865  
(Month) (Day) (Year)

Immediate cause of death Mitral Insufficiency Duration years

8. AGE: Years 75 Months 8 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Warsaw Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Other conditions Very High Blood Pressure year \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name William Crosslin  
13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Lancen  
15. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Mrs Ida Baby lot  
(b) Address Archie, Mo.  
17. (a) Burial (b) Date thereof Nov. 13, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Orient Cemetery  
18. (a) Signature of funeral director Atkinson Bros.  
(b) Address Archie, Mo.  
19. (a) 11-13-40 (b) Mrs Dora Adair  
(Date received local registrar) (Registrar's signature)

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? 140  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature B. B. Jout (M. D. or other) \_\_\_\_\_  
Address Archie, Mo. Date signed 11/11/40

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

MOTHER FATHER

**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

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

*Floyd W. Hanson*

Licensed Embalmer No. \_\_\_\_\_

3920

P. O. Address \_\_\_\_\_

*Hansonsville*

**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.**