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DEPARTMENT OF COMMERCE
OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25966

Registration District No. 1941 3 E

Primary Registration District No. 2-964

State File No. _____

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Rural Prairie, Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Randolph
(c) City or town Rural Prairie
(If outside city or town limits, write "RURAL")
(d) Street No. 8
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
year 1941 hour 9 minute A. M.
21. I hereby certify that I attended the deceased from 1939
1939 to July 17, 1941
that I last saw her alive on July 16, 1941
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME NANCY C. CORDELLA KASSATT
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F 1 race W 5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife CHARLES KASSATT
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 16 1966
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 2
If less than one day _____ hr. _____ min.

9. Birthplace Randolph County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____
12. Name John Dominant
13. Birthplace not known 9
(City, town, county) (State or foreign country)
14. Maiden name Elizabeth Johnson
15. Birthplace Mass Co. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jennell Stickney
(b) Address R. 1, Hickman, Missouri
17. (a) Burial (b) Date thereof July 19, 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Burial
18. (a) Signature of funeral director S. S. Miller
(b) Address Hickman, Mo.
19. (a) _____ (b) G. J. Hinesbaugh
(Date received local registrar) (Registrar's signature)

Immediate cause of death By po. static pneumonia 2 day
Due to Chronic Bronchitis
Due to _____
Other conditions 118
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. A. Woods (M. D. or other) D
Clark Mo. Date signed _____

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

RECEIVED

District Health Officer No. 10

District File Number 8-41-1428

Date Filed AUG 6 1941

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.....

Licensed Embalmer No. 3978

P. O. Address Glasgow, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35966
Registrar's No. 8

Registration District No. 736

Primary Registration District No. 5964

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

1. PLACE OF DEATH:
 (a) County Randolph
 (b) City or town Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Nancy C. Kassmann
 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 wid
 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 _____ Months _____ Days _____
If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-24-1941 (b) J. Kinnough
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____



