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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 20 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3279

State File No.

Registration District No. 125

Primary Registration District No. 5962

Registrar's No. 4

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Saline Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Monroe City R.F.D. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 7 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Monroe
(c) City or town Monroe City
(If outside city or town limits, write "RURAL")
(d) Street No. 117 2nd Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Catherine Rhoda Tooley

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George W.

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

7. Birth date of deceased November 23 1860
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
82	2	2	hr. min.

9. Birthplace Ralls County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name James F. Cassiday
13. Birthplace D.K. Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Calista Hinton
15. Birthplace D.K. Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carrie Hampton
(b) Address Monroe City Mo R 2

17. (a) Burial (b) Date thereof 1/28/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Judes Cemetary

18. (a) Signature of funeral director Wilson & Sons
(b) Address Monroe City; Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25th year 1942 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Jan 17 1942 to Jan 25 1942 that I last saw her alive on Jan 25 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure following shock to the Cardio-Vascular system | Duration: [illegible]

Due to falling down on concrete sidewalk & fracture | Duration: 2 days

Due to of the right humerus at shoulder

Other conditions Senility
(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) accidental fall
(b) Date of occurrence Jan 17 1942
(c) Where did injury occur? Monroe City Monroe Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home - front walk
(Specify type of place)
While at work? Walking (e) Means of injury Fall

23. Signature [illegible] (M. D. or other) MD
Address Monroe City Mo Date signed 1/27/42

1120

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-42-322
FEB 19 1942
Date Filed

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~~ By me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Leslie L. Nelson

Licensed Embalmer No. 3014

P. O. Address Monroe City 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.

. S. No. 2B
)M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3279

Registration District No. 930 Primary Registration District No. 5962 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Ralls
(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)

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

3. (a) PRINT FULL NAME Catherine R. Fowley.
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 Nov (Month) 23 (Day) 88 (Year)

8. AGE: Years 82 | Months 2 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1/28/42 (Date received local registrar) (b) Mrs. Earl Perkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
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?
(Specify type of place)
While at work? (c) Means of injury

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

SUPPLEMENTARY