No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 18 1942

Registration District No. 146

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40920

State File No.

Primary Registration District No. 3026

Registrar's No. 304

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Independence Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence (If outside city or town limits, write "RURAL")
(d) Street No. 1309 South Main (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME REASE CASON
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maud Cason
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Aug. 22 (Month) 1883 (Day) (Year)

8. AGE: Years 59 Months 2 Days 27 If less than one day hr. min.
9. Birthplace Shiloh Dent Co Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name John Cason
13. Birthplace Frankfort Co Mo (City, town, or county) (State or foreign country)
14. Maiden name Amanda Cockrell
15. Birthplace Grow Ridge Mo (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Maud Cason
(b) Address 1309 So. Main
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/22/42 (Month) (Day) (Year)
(c) Place: burial or cremation Cuba Mo.
18. (a) Signature of funeral director Geo. C. Carson
(b) Address Independence Mo.
19. (a) 11-22-42 (Date received local registrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19 year 1942 hour 8 minute 00 P.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 acute Dilatation of Heart	few minutes
Due to Myocarditis	years
Due to acute Nephritis	6 wks
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Geo. E. Bryan (M. D. or other)
Address Independence Mo. Date signed 11/20/42

(Licensed Embalmer's Statement on Reverse Side)

By Tom Tuggman

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 Frank Bee Bird

Licensed Embalmer No. 2467

P. O. Address Lodge. Mo.

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

If this body is not embalmed, fact should be so stated above.

. No. 2B
—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 8 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40920

Registration District No. 3146 | Primary Registration District No. 3026 | Registrar's No. 304

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Independence Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1/2 da (Specify whether years, months or days)
In this community 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Independence (If outside city or town limits, write "RURAL")
(d) Street No.: 1309 Sout Main (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Reese Cason
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Maud
6. (c) Age of husband or wife if alive: 57 years
7. Birth date of deceased: Aug 22 (Month) — 1883 (Day) (Year)
8. AGE: Years 59 | 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: John Cason
13. Birthplace: (City, town, or county) Mo (State or foreign country)
14. Maiden name: Amanda Cochran
15. Birthplace: (City, town, or county) Mo. (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1 year 1942 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: Acute dilatation of heart	
Due to: Myocarditis	
Due to: Acute Nephritis	
by Upper Respiratory Infection	4-5d
Other conditions (Include pregnancy within 3 months of death): 8	
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: George C Thomas (M. D. or other)
Address: Independence Mo Date signed 1/14/43

SUPPLEMENTARY

10 x a