

FILED SEP 2 1944

Registration District No. 59

Primary Registration District No. 5219

Registrar's No. 130

19
00
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Camp Branch Twp.
(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 25 yr
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Rural Pleasant Hill Twp.
(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 0

3. (a) PRINT FULL NAME R. B. CASSODY

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Amey Belle Casody
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 11 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 14
If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Wm Casody

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

14. Maiden name Mary Catharine Hens

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

16. (a) Informant Mrs. Robert Mc Kee

(b) Address Harrisonville Mo

17. (a) Rural (b) Date thereof 8 27 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orient Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S
(b) Address HARRISONVILLE, MO.

19. (a) Aug. 29, 1944 (b) Margaret Talle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1944 hour 11:00 minute P M.

21. I hereby certify that I attended the deceased from Aug 2 - 1944 to Aug 20 1944
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate Gland

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 West (M. D. or other) 44

Address Harrisonville Date signed Aug 26

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... Ernest D. Rannenburg

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.