S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1945

Registration District No. 184

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

State File No. 17362

Registrar's No. 454

Patten

1. PLACE OF DEATH

(a) County Linn

(b) City or town Brookfield
(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 Mo (b) County Linn 58

(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL") 2

(d) Street No. 422 Market
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME LARRY JO. CASS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M O

5. Color or race K

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) - 19 (Day) - 1945 (Year)

8. AGE: Years 0 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Brookfield (City, town, or county) Mo D (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Cass
13. Birthplace Linn Co (City, town, or county) Mo D (State or foreign country)

MOTHER
14. Maiden name Ruth D Bailey
15. Birthplace Linn Co (City, town, or county) Mo D (State or foreign country)

16. (a) Informant John Cass
(b) Address Brookfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr (Month) - 28 (Day) - 1945 (Year)
(c) Place: burial or cremation ~~Rose Hill~~ New Boston

18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo

19. (a) 4-27-1945 (Date received local registrar) (b) W W Cowen (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 26 year 1945 hour 9 minute 10 M.

21. I hereby certify that I attended the deceased from 4-19-45, 19, to 4-26, 1945 that I last saw him alive on 4-25-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Abdominal

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration: Few Hours

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 H. H. Patten (M. D. or other) P. O.

Address Brookfield Mo Date signed 4-27-45

456

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number
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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.