No. 2
-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 25 1945

State File No. 30872

Registration District No. 383 Primary Registration District No. ~~383~~ 3037 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon Hup
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether
In this community 14 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45

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

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Case

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Cornelia Stapleton Case

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

7. Birth date of deceased May (Month) 30 (Day) 1884 (Year)

8. AGE: Years 61 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Camden City (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Edmund Case 0
13. Birthplace Laclede City (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Martha
15. Birthplace Unknown (City, town, or county) Unknown 0 (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk
(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) R. (Burial, cremation, or removal) (b) Date thereof 9-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) ~~9-3~~-45 (Date received local registrar) (b) [illegible] Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept. day 3d
year 1945 hour 12:00 minute Noon M.

21. I hereby certify that I attended the deceased from Aug 21, 1945, to Sept. 3, 1945
that I last saw him alive on Sept. 3, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13

Major findings: For adv. pulm. Tbc (miliary spread); Tbc pericarditis (adhesive)
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Y. F. Kuykawa (M. D. or other) MD
Address Mt Vernon, Mo. Date signed 9/3-45

1464

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 9 54-987
Date Filed 9-24-45

OCT 1 194

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 R. A. Palmer

Licensed Embalmer No. 1167

P. O. Address Lebanon 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.

No. 2B
3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 383 Primary Registration District No. 3037 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt Vernon Twp
(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 years, months or days)

In this community

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 William Case

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 30 (Day) (Year)

8. AGE: Years 61 Months 3 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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 9 3 45 (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

(a) Signature of funeral director A. Palmer F. H.

(b) Address Lebanon Mo

19. (a) 9-3-45 (Date received local registrar) (b) O. P. Philbrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 3 year 1945 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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

30872

1/19/45

~~Do not have~~
~~info requested.~~
~~CRP~~ ~~Dep. Reg~~

orig bert
mailed moved.
~~9/21/45~~