S. No.
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41894

Registration District No. 219 Primary Registration District No. 5791-5792 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Moniteau Co.

(b) City or town High Point, Mo. Harrison Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: High Point, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 43 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau 68

(c) City or town High Point, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. High Point, mo, 0
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME Cassie Jane Nail

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

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

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

7. Birth date of deceased Aug (Month) 22 (Day) 1850 (Year)

8. AGE:

Years	Months	Days	If less than one day
86	1	0	..... hr. ..... min.

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

10. Usual occupation House Wife

11. Industry or business .....

FATHER
12. Name Basel Evans
13. Birthplace ..... (City, town, or county) Kent (State or foreign country)

MOTHER
14. Maiden name Sarah Nail
15. Birthplace ..... (City, town, or county) Kent (State or foreign country)

16. (a) Informant C. H. Nail
(b) Address High Point, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation High Point Cemt.

18. (a) Signature of funeral director Bowlin Funeral Home
(b) Address California, Mo.

19. (a) 1/9/46 (Date received local registrar) (b) C. H. Nail (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22
year 1945 hour 3/30 minute P.M.

21. I hereby certify that I attended the deceased from 9-10-45, 19..., to 9-22-45, 19...;
that I last saw er alive on 9-21-45, 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Ureania 4 days

Due to Chronic interstitial Nephritis Years

Due to Artelriosclerosis Years

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

Major findings:
Of operations X
Of autopsy X

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 E. C. Shelton (M. D. ~~or other~~)
Address Eldon, Mo Date signed 9.24.45

1672

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-14-46

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 Mr. ....., Registered Apprentice No. ....., working under my personal supervision.

Signed Earl R. Boulin

Licensed Embalmer No. 2126

P. O. Address California, 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.