

No. 2  
4-2-43  
5-17-39  
1 X33697

FILED FEB 11 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. 3127 Registrar's No. 14

1. PLACE OF DEATH:

(a) County Jasper County Mo

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

(c) Name of hospital or institution: Dr. Flager's Hospital  
(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) 25 years

3. (a) PRINT FULL NAME Charles Marion Cass

3. (b) If veteran, name war. XX

3. (c) Social Security No. XX

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

6. (b) Name of husband or wife Emma R 6. (c) Age of husband or wife if alive years  
April 1883  
(Month) (Day) (Year)

8. AGE: Years 17 1/2 62 Months 9 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas P Cass 1

13. Birthplace Ohio 1  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Jane Hart  
15. Birthplace West Virginia 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Emma R Cass  
(b) Address Wellsburg, W. Va

17. (a) Removed (b) Date thereof Jan 9 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crocker Cemetery  
Wellsburg, W. Va

18. (c) Signature of funeral director F. H. Schmitt  
(b) Address Ottawa, Kansas

19. (a) JAN 24 46 (b) J. E. Distal  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Wellsburg Mo 5  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 3

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1946 hour 6 minute 10 P. M.

21. I hereby certify that I attended the deceased from Jan 19 46 to Jan 21 19 46 that I last saw him alive on Jan 21 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary edema  
Chronic interstitial nephritis  
Chronic fibroid  
Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 1, 2, 3

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

Signature R. M. Stymant (M. D. or other) M.D.  
Address Wells City MO Date signed 1/24/46

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

46-1-17

**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..... *E. O. Hedge* .....

Licensed Embalmer No. *2859* .....

P. O. Address..... *Webb City, 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.**