

**FILED** MAY 20 1946

Primary Registration District No. **5984**

Registrar's No. **43**

1. PLACE OF DEATH:

(a) County **PUGASKI**

(b) City or town **WAYNESVILLE ROUT 1**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **LIBERTY TWS.**  
(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 **Julesburg Co.**

(c) City or town **Waynesville Mo. Route 1**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Liberty Tws.**  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Ethel Mae Cassoll**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **21**  
year **1946** hour **7** minute **AM**

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **HAMTEN CASSOLL** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **AUG 16 1890**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr 20** 19**46** to **Apr 21** 19**46**  
that I last saw her alive on **10pm 20 April** 19**46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **12 hrs**

8. AGE: Years **55** Months **8** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Hyperpericardial Cardiac Arteriosclerotic Disease**

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

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

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

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

Of autopsy **938**

10. Usual occupation **Housewife**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name **Franklin O. Hub**

13. Birthplace **Wester Mich**  
(City, town or county) (State or foreign country)

14. Maiden name **Lillian McPherson**

15. Birthplace **Bunker Hill Ill**  
(City, town or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **Hampden Cornell**

(b) Address **Waynesville Mo. Route 1**

17. (a) **Burial** (b) Date thereof **4/21/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Lawn**

18. (a) Signature of funeral director **R. B. Dupre**

(b) Address **Richland Mo.**

19. (a) **5/9/46** (b) **Janice B. McPherson**  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **Ray H. Reed** (M. D. or other) \_\_\_\_\_

Address **Richland** Date signed **5/16/46**

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

13031

**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.

*Not Embalmed*

Signed..... *R.B. Jumper*  
Licensed Embalmer No. *3198*  
P. O. Address..... *Richland 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.**