No. 2
2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29451

Registration District No. 3 Primary Registration District No. 5020 Registrar's No.

1. PLACE OF DEATH:

(a) County Atcheson

(b) City or town Rural near Hamburg, Iowa
(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 70 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atcheson

(c) City or town Rural near Hamburg, Iowa
(If outside city or town limits, write "RURAL")

(d) Street No. 5 miles southwest Hamburg, Iowa
(If rural, give location)

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

If yes, name country ---------

3. (a) PRINT FULL NAME WILLIAM L. CASS

3. (b) If veteran, name war NONE.

3. (c) Social Security No. 492-14-5326

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife JULIA MYRTLE GRABLE CASS

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March (Month) 27, (Day) 1873 (Year)

8. AGE:

Years	Months	Days	If less than one day
73	3	6	hr. min.

9. Birthplace Geneseo, (City, town, or county) Illinois / (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name Lew Cass
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Sisk
15. Birthplace (City, town, or county) Tennessee / (State or foreign country)

16. (a) Informant Julia Cass
(b) Address Hamburg, Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7- - 46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Zion Cemetery

18. (a) Signature of funeral director C. E. Berham
(b) Address Rock Port Missouri

19. (a) 10-11-46 (Date received local registrar) (b) J. A. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3rd year 1946 hour 18 minute P. M.

21. I hereby certify that I attended the deceased from Was dead when I was called on case that I last saw him alive on June 1 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion.	Sudden
Due to: Chronic Cardio. renal, vascular disease	2 years
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

131A

Major findings:
Of operations Coronary occlusion
Of autopsy none.

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 R. W. Sykes (M. D. or other) M.D.
Address Hamburg, Iowa Date signed 7-5-46.

3 (Licensed Embalmer's Statement on Reverse Side)

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

C. E. Bertram, Registered Apprentice No.

working under my personal supervision.

Signed C. E. Bertram

Licensed Embalmer No. 1764

P. O. Address Rock Port 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. Ce N

Registration District No. 3 Primary Registration District No. 5020 Registrar's No.

1. PLACE OF DEATH:

(a) County: Atchison

(b) City or town: (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 L. Carr

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

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: Mar (Month) 27 (Day) 1873 (Year)

8. AGE: Years 73 Months 3 Days Unless less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

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 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 10/11/46 (Date received local registrar) (b) J. A. Grays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1946 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.

Immediate cause of death — Duration

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

29451