

S. No. 2
-1/47
G-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 2 1947
Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 3033

38772
State File No.
Registrar's No.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 324 N. Madison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 mo. (Specify whether
In this community 7 mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Laclede 53
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. 224 N. Madison
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME Dovie Frances Casey
3. (b) If veteran, name war..... 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 12
year 1947 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from July 15
1947 to Nov. 12 1947
that I last saw her alive on October 10 1947
and that death occurred on the date and hour stated above.

5. Color or race W
6. (a) Single, widowed, married, divorced, Unmarried
4. Sex F
6. (b) Name of husband or wife Geo. Casey 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Nov. 20 1981
(Month) (Day) (Year)

Immediate cause of death Cancer
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
66 11 21 hr. min.

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION
Underline the cause of death which should be charged statistically.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name unknown

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

14. Maiden name Nancy Pearson

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

16. (a) Informant Mrs. Homer Latham

(b) Address Lebanon Mo.

17. (a) Burial (b) Date thereof 11/14/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rogers Ark.

18. (a) Signature of funeral director Palmer

(b) Address Lebanon Mo.

19. (a) Nov. 22, 1947 (b) Ch. Frankberger
(Date of local registrar) (Registrar's signature)

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?.....
While at work?..... (e) Means of injury.....
23. Signature H. C. Carrington (M. D. or other) M. D.
Address Lebanon Mo. Date signed 11/17/47

Received 12/1/47

County Health Unit

11-47-202

Date filed 12/1/47

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

Richard L. Palmer

Registered Apprentice No. *84*

working under my personal supervision.

Signed *Allyn D. Hooker*

Licensed Embalmer No. *4333*

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.

Registration District No. 170

Primary Registration District No. 0033

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(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 _____ years, months or days

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 David F. Casey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days _____ If less than one day _____ hr. _____ min

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. Carrington (M. D. or other) M.D.
Address Lebanon, Mo. Date signed 12/12/44

SUPPLEMENTARY

CANCER, PRIMARY IN RIGHT MANDIBLE

Duration

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PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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