

FILED APR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9147

State File No.

BIRTH NO.		REG. DIST. NO. <u>195</u>		PRIMARY REG. DIST. NO. <u>5707</u>		Registrar's No. <u>21</u>		
1. PLACE OF DEATH a. COUNTY <u>McDonald</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural McMullen</u>		c. LENGTH OF STAY (in this place) <u>7 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>				d. STREET ADDRESS (If rural, give location) <u>Anderson, Mo. R#1 0</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Wasson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 21 1949</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January 4 1876</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>17</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Joseph Wasson</u>		13b. MOTHER'S MAIDEN NAME <u>Evylin Bell</u>		14. NAME OF HUSBAND OR WIFE <u>Lottie Wasson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. (If yes, state year or date of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lottie Wasson</u>		ADDRESS <u>Anderson, Mo R#1</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Arteriosclerotic Nephritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic Carcinoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>444X</u>	
19a. DATE OF OPERATION <u>3-21-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Prostatic Carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>12/15, 1948</u> , to <u>3/21, 1949</u> , that I last saw the deceased alive on <u>3/21, 1949</u> , and that death occurred at <u>5:30 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Wm H Martin D.O.</u>				23b. ADDRESS <u>Southwest City, Mo.</u>		23c. DATE SIGNED <u>3/24/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-24-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mayfield Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>E. of Anderson, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>3-28-49</u>		REGISTRAR'S SIGNATURE <u>Mayne Humphrey</u>		423 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Morris Pope</u>		ADDRESS <u>Weston, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.4800
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RECEIVED

District Health Officer

District File Number 449

Date Filed 4-6-4

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

James R. Duncan
working under my personal supervision.

Student Embalmer No. 308

Student
Student Embalmer

Signed Wm Morris Payne

Licensed Embalmer No. 3447

P. O. Address Wheaton, Md

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.