

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 2 1949

State File No. 18545  
24

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 6 PRIMARY REG. DIST. NO. 5081 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cuire Rural 1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Cuire</u>	
c. LENGTH OF STAY (In this place) <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>3 miles West of Vandalia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3 miles West Vandalia</u>		d. STREET ADDRESS (If rural, give location) <u>3 miles West of Vandalia</u>	

3. NAME OF DECEASED a. (First) <u>Margaret</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Cassiday</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 22 1949</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan 2 1898</u>		9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Days <u>5</u> Hours <u>20</u>		IF UNDER 24 HRS. Hours <u>20</u> Min.	
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			11. BIRTHPLACE (State or foreign country) <u>Vandalia Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
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13a. FATHER'S NAME <u>John Barnes</u>			13b. MOTHER'S MAIDEN NAME <u>Emmeline Tipton</u>			14. NAME OF HUSBAND OR WIFE <u>John Bill Cassiday</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>NO.</u>			17. INFORMANT'S SIGNATURE OR NAME <u>John Bill Cassiday</u>			ADDRESS <u>Farber Mo</u>		
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-Weeks</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma right breast with metastasis to Lungs</u>						4-yr	
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						170X	

19a. DATE OF OPERATION <u>3-21-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Axillary glands involved</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) m.		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 March 20, 1949, to June 22, 1949, that I last saw the deceased alive on June 22, 1949, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W K McCall MD U</u>		23b. ADDRESS <u>Ladonia Mo</u>		23c. DATE SIGNED <u>6-23-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 24 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Farber Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Farber Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>6/24/49</u>		REGISTRAR'S SIGNATURE <u>Malcolm Ferguson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Waters</u>		ADDRESS <u>Vandalia Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer N

District File Number 7-49-

Date Filed JUL 1 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed William B. Waters

Licensed Embalmer No. 4169

P. O. Address Vandalia 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.