

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18798

FILED JUL 9 1949

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 218

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY Osage b. CITY OR TOWN Bonnets Mill, Mo	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton c. LENGTH OF STAY (in this place) 3 mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bonnets Mill	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 1		d. STREET ADDRESS (If rural, give location) -	

3. NAME OF DECEASED (Type or Print) a. (First) William Maaseen b. (Middle) - c. (Last) Maaseen	4. DATE OF DEATH (Month) (Day) (Year) 6 - 27 - 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED? (Specify) Single	8. DATE OF BIRTH May - 18 - 1878	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months 1 Days 9	IF UNDER 2 HRS. Hours - Min. -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Mo	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Herman Maaseen	13b. MOTHER'S MAIDEN NAME Mary Schuelan	14. NAME OF HUSBAND OR WIFE -
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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) DK	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME August Schafer ADDRESS -
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral atherosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from 6-18-49, 19 , to 6-27-49, 19 , that I last saw the deceased alive on 6-27-49, 19 , and that death occurred at 8:10 Pm., from the causes and on the date stated above.

23a. SIGNATURE M. J. Miller (Degree or title) D	23b. ADDRESS State Hospital No 1, Fulton, Mo	23c. DATE SIGNED 6-27-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 29/49	24c. NAME OF CEMETERY OR CREMATORY Loose Creek	24d. LOCATION (City, town, or county) (State) Lynn Mo
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DATE REC'D BY LOCAL REG. June 27-1949	REGISTRAR'S SIGNATURE Maretta Lawrence	426	25. FUNERAL DIRECTOR'S SIGNATURE Morton Funeral Home ADDRESS Lynn Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 6 1949
District Health Officer No. 9,
District File Number

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 *Leison M. Moton*

Licensed Embalmer No. *4125*

P. O. Address *Lincoln, 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.