

FILED JUL 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22415**

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **211**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Schuyler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. LENGTH OF STAY (In this place) 1 day	
d. FULL NAME OF HOSPITAL OR INSTITUTION Laughlin Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Queen City	
		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) ALBY	a. (First)	b. (Middle)	c. (Last) CASWELL	4. DATE OF DEATH July 15, 1949	(Month) (Day) (Year)
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 16, 1883	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Queen City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Ransom Caswell	13b. MOTHER'S MAIDEN NAME Sarah E. Little	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Alva Caswell	ADDRESS Queen City, Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia (Lobar)		INTERVAL BETWEEN ONSET AND DEATH 2 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) myocardial weakness		
	DUE TO (c) unidentified pathology of liver		
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 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)
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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 **July 14, 1949**, to **July 15, 1949** that I last saw the deceased alive on **July 13, 1949**, and that death occurred at **6:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE A. J. Rhoads, D.O.	(Degree or title)	23b. ADDRESS Kirksville, Mo.	23c. DATE SIGNED 7-17-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7/15/49	24c. NAME OF CEMETERY OR CREMATORY Queen City Cemetery	24d. LOCATION (City, town, or county) (State) Queen City Mo.
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DATE REC'D BY LOCAL REG. 7-19-49	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Wm. G. West	ADDRESS Queen City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 26 1949
District Health Officer No. 10
District File Number 7-49-731
Date Filed JUL 26 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 Self

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Licensed Embalmer No. 2882

P. O. Address. Queens City 9

Notes: 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.