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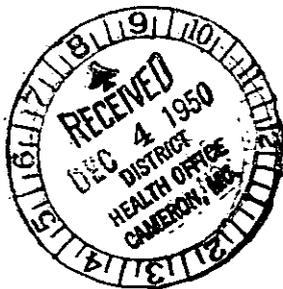
THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 5 1950

State File No. 36390
Registrar's No. 205

BIRTH NO.		REG. DIST. NO. 55		PRIMARY REG. DIST. NO. 36390		Registrar's No. 205		
1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Carroll				
b. CITY (If outside corporate limits, write RURAL and give township) Rural Combs		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Combs Township		d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) Lawrence W. Cahill			a. (First) W. b. (Middle) Cahill c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) NOV 23 1950		
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JAN 1, 1864		
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months 10 Days 2		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MO O		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Patrick Cahill			13b. MOTHER'S MAIDEN NAME Elizabeth Seward			14. NAME OF HUSBAND OR WIFE Lillie Jane Cahill		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sue Chambers Carrollton Mo				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia				INTERVAL BETWEEN ONSET AND DEATH 3 2nd				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES				
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) nephritis				
				DUE TO (c) arteriosclerosis				
II. OTHER SIGNIFICANT CONDITIONS				CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility age 86				
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 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 July , 1950, to Nov 23 , 1950, that I last saw the deceased alive on Oct 18 , 1950, and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE [Signature]				23b. ADDRESS Carrollton Mo		23c. DATE SIGNED 11-24-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-25-50		24c. NAME OF CEMETERY OR CREMATORY Slater Cemetery		24d. LOCATION (City, town, or county) (State) Slater, Mo		
DATE REC'D BY LOCAL REG. 11/25/50		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. H. Dickerson Bogard Mo				

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



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.....

E. A. Dickerson

Licensed Embalmer No.

2534

P. O. Address.....

Bogard MD

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.