

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5408**

FILED MAR 1 1954

BIRTH NO. _____ REG. DIST. NO. **195** PRIMARY REG. DIST. NO. **5715** Registrar's No. **18**

660
4

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

1. PLACE OF DEATH a. COUNTY McDonahd		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY McDonahd	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JANE (Rural)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JANE	
d. FULL NAME OF HOSPITAL OR INSTITUTION Nursing Home		d. STREET ADDRESS (If rural, give location) 0660-1	

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle) P.	c. (Last) CASHMEYER	4. DATE OF DEATH (Month) (Day) (Year) 2-15-1954
-------------------------------------	--------------------------	-----------------------	----------------------------	--

5. SEX M	6. COLOR OR RACE M	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NM	8. DATE OF BIRTH Nov. 30-1867	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 1 HR. Hours 1 Min.
-----------------	---------------------------	--	--------------------------------------	---	--	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY SAME	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US
---	---	---	--

13a. FATHER'S NAME ISSAC CASHMEYER	13b. MOTHER'S MATHEN NAME ANNA BAUM	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Brother Terrence Adams, Ill.	ADDRESS 490x
--	-------------------------------------	---	---------------------

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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 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)	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 **Jan**, 19**53**, to **Feb 15**, 19**54**, that I last saw the deceased alive on **Feb 12**, 19**54**, and that death occurred at **6:00 P** m., from the causes and on the date stated above.

23a. SIGNATURE Carl Hubbell	(Degree or title) MD	23b. ADDRESS Pineville Mo.	23c. DATE SIGNED 2/27/54
------------------------------------	-----------------------------	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-16-54	24c. NAME OF CEMETERY OR CREMATORY HARRIS CEMETERY	24d. LOCATION (City, town, or county) (State) TABLE GROVE FULTON Co, Ill.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 2-27-54	REGISTRAR'S SIGNATURE Magnum Humphrey	423-0	25. FUNERAL DIRECTOR'S SIGNATURE Raylow Funeral Home	ADDRESS Cuba, Ill.
---	--	-------	---	---------------------------

1945

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 Mayne E. Humphreys

Licensed Embalmer No. 4262

P. O. Address Princeton

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.