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FILED DEC 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37982

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 4311 Registrar's No. 14

1. PLACE OF DEATH
a. COUNTY Macou
b. CITY OR TOWN Callao
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission).
a. STATE Mo b. COUNTY Macou
c. CITY OR TOWN Callao
d. Is Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) Steto

3. NAME OF DECEASED
a. (First) Sarah b. (Middle) Adelia c. (Last) Cashatt

4. DATE OF DEATH (Month) (Day) (Year) 11-8-54

5. SEX Female
6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 10-10-21

9. AGE (In years last birthday) 33
if UNDER 1 YEAR: Months _____ Days _____
if UNDER 6 HRS: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired) Homemaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Newman, Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Wm. De Witt

13b. MOTHER'S MAIDEN NAME Rebecca Willis

14. NAME OF HUSBAND OR WIFE H. G. Cashatt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME Geneva Murphy ADDRESS Kynchester, Mo

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Failure
ANTECEDENT CAUSES
DUE TO (b) Chronic Myocarditis
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Thrombo-phlebitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 4222

20. AUTOPSY? YES NO

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) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from 7-14-1954, to 11-8-1954, that I last saw the deceased alive on 11-8-1954, and that death occurred at 820 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank H. Callin, D.O.

23b. ADDRESS Berwyn, Mo

23c. DATE SIGNED 11-8-54

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE 11-11-54

24c. NAME OF CEMETERY OR CREMATORY Forest Grove Cem

24d. LOCATION (City, town, or county) (State) Callao Mo

DATE REC'D BY LOCAL REG. 11/20/54

REGISTRAR'S SIGNATURE John M. Neely

25. FUNERAL DIRECTOR'S SIGNATURE H. S. Edwards ADDRESS Berwyn, Mo

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

DEC 10 1954

RECEIVED

11-29-54

MACON COUNTY HEALTH DEPARTMENT
County File No. 11-54-184
Date Filed 11-30-54

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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.....
Signature of Student Embalmer

Signed *A. G. Edwards*.....

Licensed Embalmer No. 196.....

P. O. Address *Revis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.