

FILED DEC 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41964

State File No.

820

820

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

BIRTH NO. _____ REG. DIST. NO. 277 PRIMARY REG. DIST. NO. 4411 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <u>Pike</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bowling Green</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>	c. CITY OR TOWN <u>Frankford</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Revering Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>0820</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> (Middle) <u>MERRITT</u> c. (Last) <u>CASH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 16 1954</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 31. 1881</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>Farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Frankford Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Thomas Cash</u>		13b. MOTHER'S MAIDEN NAME <u>Virginia Waddell Maus Cash</u>	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>7</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Maus Cash</u>		ADDRESS <u>Frankford Mo</u>	
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) <u>Extensive Carcinoma of Prostate</u>			DUE TO (b) _____		
ANTECEDENT CAUSES Morbid 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.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>177 X</u>		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 <u>Apr.</u> , 19 <u>45</u> , to <u>Dec.</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Dec. 15</u> , 19 <u>54</u> , and that death occurred at <u>5:41</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>E. P. Hansen, D.O.</u>			23b. ADDRESS <u>Frankford Mo.</u>		23c. DATE SIGNED <u>12/17/54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 18-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	24d. LOCATION (City, town, or county) (State) <u>Frankford Mo.</u>		
DATE REC'D BY LOCAL REG. <u>12/21/54</u>	REGISTRAR'S SIGNATURE <u>Bill Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fields & Son</u> ADDRESS <u>Frankford, Mo.</u>		

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..... *Jose Fields Megaw*

Licensed Embalmer No..... *409*

P. O. Address..... *Franklin*

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.