

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43128**

BIRTH NO. 94684-54 REG. DIST. NO. 338 PRIMARY REG. DIST. NO. 6148 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Dexter, Mo. R. 2		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Castor 1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Dennis	b. (Middle) Wayne		c. (Last) Cahow		Dec. 8, 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH Nov. 28, 1954		9. AGE (In years last birthday) -- IF UNDER 1 YEAR -- MONTHS -- DAYS 10 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Dexter, Mo. R. #2 0	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Casper C. Cahow	13b. MOTHER'S MAIDEN NAME Tersa Pearl Hester	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -----	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Casper C. Cahow ADDRESS Dexter, Mo. R. #2
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	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"/>
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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)	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 28 Nov. 1954, to Dec 8, 1954, that I last saw the deceased alive on Dec 8, 1954, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE D. Waddle, M.D. (Degree or title)	23b. ADDRESS Dexter, Mo.	23c. DATE SIGNED 2 Dec 1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 9, 1954	24c. NAME OF CEMETERY OR CREMATORY Harper Cemetery	24d. LOCATION (City, town, or county) (State) Near Aid, Mo. Mo.
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DATE REC'D BY LOCAL REG. 12-29-1954	REGISTRAR'S SIGNATURE Lois K. Maoney 510-0	25. FUNERAL DIRECTOR'S SIGNATURE Chiles Und. Co. ADDRESS Bloomfield, Mo.
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(Licensed Embalmers' Statement on Reverse Side)

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

1030
1

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 _____

Child was not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *No Embalming*

Licensed Embalmer No. _____

P. O. Address _____

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.