

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002151

STATE FILE NUMBER

FILED JAN 15 1959 Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Miss.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston</b> 06720
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>313 W. Ironbank</b>		Length of stay in lb <b>life</b>	d. STREET ADDRESS (If outside, give location) <b>313 W. Ironbank</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Suliven Cassell</b>			4. DATE OF DEATH Month Day Year <b>Jan. 3, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1891</b>
9. AGE (In years last birthday) <b>67</b>		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, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Wolf Island, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Walt Cassell</b>	
13b. MOTHER'S MAIDEN NAME <b>Janie Adkins</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Cassell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>527-32-4629</b>	17. INFORMANT Address <b>Mrs. Sarah Cassell, 313 Ironbank, Charleston, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcal throat.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Dec 28 58</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>onset of upper respiratory</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>general debility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Death occurred at <b>See 28 58</b> to <b>Jan 3 59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Jan 3 1959</b>		and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>E. Cheslowicz MD</b>		22b. ADDRESS <b>Charleston Mo</b>	22c. DATE SIGNED <b>1/3/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 7, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Charleston, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>L.R. Sparks Charleston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hutton</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

RECEIVED  
Miss. Co. Health Dept  
County File No. \_\_\_\_\_  
Date Filed 1-13-33

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 Eddie Middleton

Licensed Embalmer No. 5046

P. O. Address Cape Girardeau, Mo.

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.