

FILED AUG 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23212

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

4200

BIRTH MO. _____		REG. DIST. NO. 137		PRIMARY REG. DIST. NO. 4213		Registrar's No. 173	
1. PLACE OF DEATH a. COUNTY Henry				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Henry			
b. CITY (If outside corporate limits, write RURAL and give township) Montrose Mo		c. LENGTH OF STAY (In this place) ✓		c. CITY (If outside corporate limits, write RURAL and give township) Montrose			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED a. (First) ANNA MARY CASBURN (Type or Print)			b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 7-1949
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed ✓		8. DATE OF BIRTH Sept 29-1865		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 83 9 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Ferdinand Hoas			13b. MOTHER'S MAIDEN NAME Victoria Kuhn		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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Mary Stout Montrose 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. myocardosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 2 yrs
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) (Min.)		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 Dec 21, 1946, to July 1, 1949, that I last saw the deceased alive on July 1, 1949, and that death occurred at 5:00 AM., from the causes and on the date stated above.							
23a. SIGNATURE W. E. Baggerly D mo.				23b. ADDRESS Montrose Mo.		23c. DATE SIGNED 7-27-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 9-1949		24c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		24d. LOCATION (City, town, or county) (State) Montrose Mo.	
DATE REC'D BY LOCAL REG. July 21-49		REGISTRAR'S SIGNATURE Florence Adair		4213		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welling Bros Montrose Mo	

RECEIVED

District Health Officer No. 7,

District File Number 7-49-902

Date Filed 8-1-49

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

7th day of July 1949

Student Embalmer No. _____

working under my personal supervision

Student _____
Student Embalmer

Signed _____

Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton City, 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 this body is not embalmed, fact should be so stated above.