

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 15 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34502

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 132-

1. PLACE OF DEATH:

(a) County COOPER
(b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ALEX VAN RAVENSWARDY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS HOSP
(Specify whether
In this community 3 DAYS
years, months or days)

3. (a) PRINT FULL NAME DONALD EUGENE CASSID

3. (b) If veteran, ☒ name war. 3. (c) Social Security No. ☒

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 11 years
7. Birth date of deceased Oct 11 1942
(Month) (Day) (Year)

8. AGE: Years 1 Months 0 Days 12 If less than one day hr. min.

9. Birthplace Moniteau Co (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name Chas & Cassid
13. Birthplace Moniteau Co (City, town, or county) (State or foreign country)
14. Maiden name Sarah & Schertz
15. Birthplace Moniteau Co (City, town, or county) (State or foreign country)

16. (a) Informant Chas E. Cassid
(b) Address Boonville Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 18 - 43 (Month) (Day) (Year)
(c) Place: burial or cremation Calisnoia City Cem

18. (a) Signature of funeral director Boonville Funeral Home
(b) Address Calisnoia Mo

19. (a) Oct 16 - 43 (Data received local registrar) (b) Dr. Chas. Swap (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County MONITEAU
(c) City or town JAMES TOWN Rural
(If outside city or town limits, write "RURAL")
(d) Street No. None (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 - 16 day 43
year 1943 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 9-20-
Sept. 20 - 1943 to 10-16 1943
that I last saw him alive on 10-16 - 43 19
and that death occurred on the date and hour stated above.

Immediate cause of death HEMIPLEGIA FROM CEREBRAL HEMORRHAGE 3 DAYS

Due to VON JACKIS ANEMIA 2-3 Mo?

Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 73d
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (c) Means of injury
23. Signature Rubey R. Kelly (M. D. or other)
Address Boonville Mo Date signed 10-16-43

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-3-43

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Earl R. Boulton*

Licensed Embalmer No. *2126*

P. O. Address *Calisornia*

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.