

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13229

MAY 27 1930

1. PLACE OF DEATH

County Linn Registration District No. 300
 Township Superior Primary Registration District No. 4303
 City Laclede (No. _____) St. _____ (Ward) _____

File No. _____
 Registered No. 3

2. FULL NAME

Isaac Newton Cassity
 (a) Residence. No. Laclede Mo St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 5 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rosa Bell Cassity

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 10 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter & Janitor
 (b) General nature of industry, business, or establishment in which employed (or employer) Janitor Laclede High School
 (c) Name of employer Laclede School Board

9. BIRTHPLACE (CITY OR TOWN) Near Milan Sullivan County Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Isaac Newton Cassity Sr.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Milan Sullivan County Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Martha Tipton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milan Sullivan County Mo
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Selia Pugh
 (Address) Wiles St. Brockfield Mo

15. FILED 5/1 1930 J. W. Busch
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 30 1930

17. I HEREBY CERTIFY, That I attended deceased from Mich, 1930 to Apr 30, 1930
 that I last saw him alive on Apr 29, 1930 and that death occurred, on the date stated above, at 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

Several years (duration) yrs. mos. ds.

CONTRIBUTORY apoplexy (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED W
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? By symptoms
 (Signed) J. W. Busch M. D.

(Address) Laclede Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Laclede City Cem. Mo DATE OF BURIAL: May 2 1930

20. UNDERTAKER M. Y. Busch ADDRESS Brockfield Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

