

JAN 2 1935

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

Do not use this space.

D. Wells  
-42590  
File No. *JH*  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

3. County *Greene* Registration District No. *318*  
Township \_\_\_\_\_ Primary Registration District No. *2001*  
City *Springfield* (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Margaret J. Casady*  
(a) Residence, No. *Buffalo, 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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 *Rosina Casady*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*56* *Unknown*  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Greene Co. Mo.*

13. NAME *John Brown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *John Brown*

15. MAIDEN NAME *Rosina Huff*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Rosina Casady Red Top Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Red Top* DATE *Dec-25-34*

19. UNDERTAKER (ADDRESS) *R. Brown Buffalo Mo.*

20. FILED *12-4* 19 *34* *Springfield Mo.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec-1-34*  
22. I HEREBY CERTIFY, that I attended deceased from *Nov 28* to *Dec 1* 19 *34*  
I last saw *her* alive on *Dec 1* 19 *34*. Death is said to have occurred on the date stated above, at *2:30* p.m.  
The principal cause of death and related causes of importance were as follows:

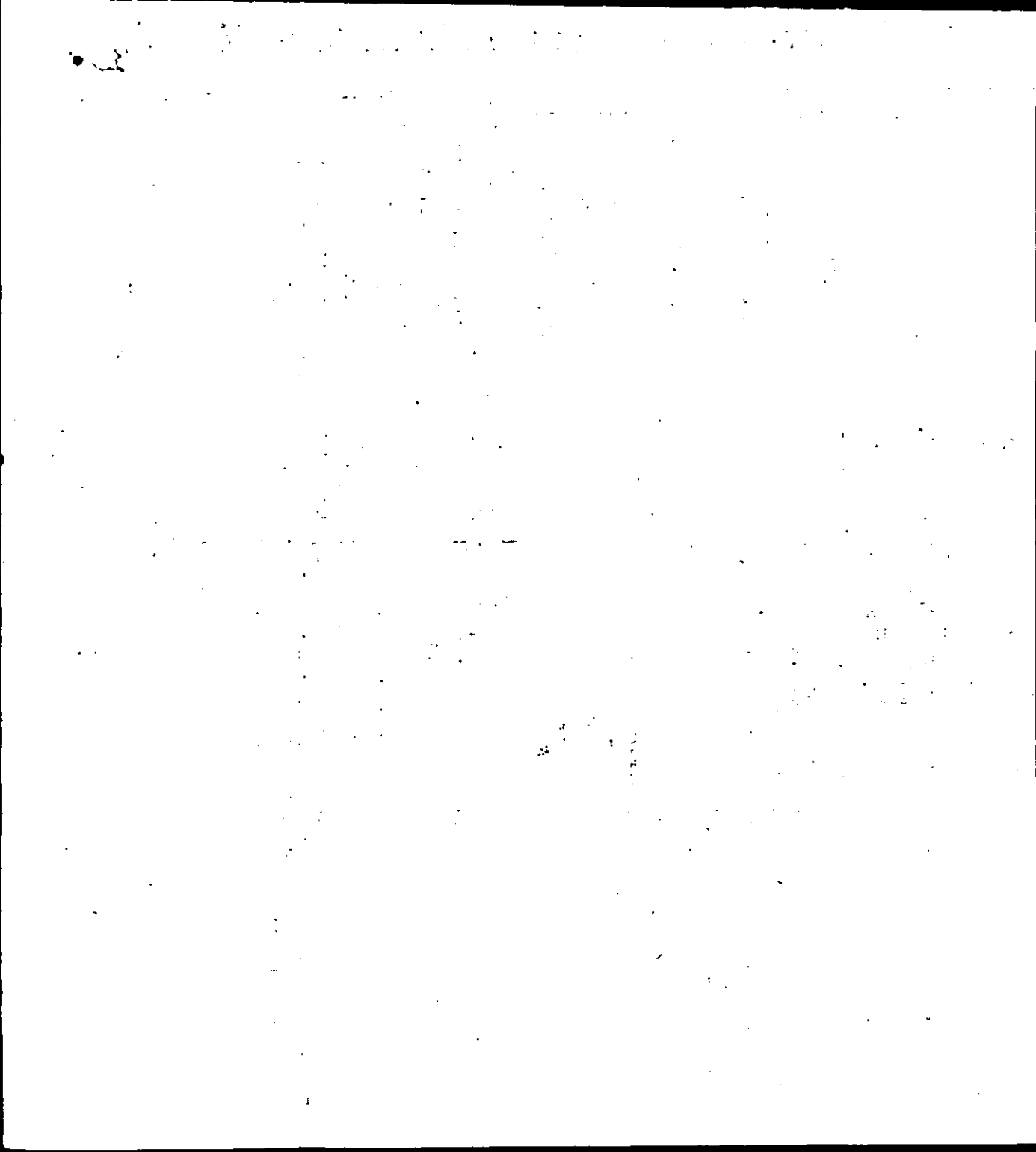
*Melero sarcous*  
*52*  
Other contributory causes of importance: *wound 52*  
Name of operation *none* Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) *Harris Smith*, M. D.  
*Springfield, Mo.*

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.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene Registration District No. 318

Township Springfield Primary Registration District No. 2001

City Springfield (No. ....) St. .... Ward)

File No. ....

Registered No. ....

**2. FULL NAME**

(a) Residence, No. .... St., .... Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S.; if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 1 1934

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

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw him alive on ....., 19.... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

to have occurred on the date stated above, at ....., m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) ....., total time (years) spent in this occupation .....

Melanoma Date of onset

Primary in face

Other contributory causes of importance:

52

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation ....., Date of .....

What test confirmed diagnosis? ....., Was there an autopsy? .....

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ....., Date of injury ....., 19....

Where did injury occur? ....., (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Manner of injury .....

Nature of injury .....

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ....., DATE ....., 19....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

19. UNDERTAKER (ADDRESS)

20. FILED 1-31 ....., 1935 John W. ... Registrar (Address) .....

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Errors of Death in human terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 9 1935

5-12-190

1935  
APR 9