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

7624

1 PLACE OF DEATH

County: Washington
Township: ~~Breton~~ — Registration District No. 887 — File No.
or Village — Primary Registration District No. 4538 — Registered No. 12
or City: Potosi Mo. (NO. ..., St.; ... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William J. Casey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6 DATE OF BIRTH: August (Month) 31 (Day) 1839 (Year)
7 AGE: 78 yrs. 5 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9 BIRTHPLACE (City or town, State or foreign country): Potosi Wash. Co. Mo

PARENTS
10 NAME OF FATHER: John Casey
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland
12 MAIDEN NAME OF MOTHER: Margaret Mulvaney
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. M. Casey
(Address) Potosi Mo.

15 Filed Feb. 7 1918 S. F. Thurman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 6 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 30, 1918, to Feb 6, 1918, that I last saw him alive on Feb 6, 1918, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
82A
97
(Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. J. Bean M. D.
Feb 6, 1918 (Address) Potosi

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Potosi Mo — DATE OF BURIAL: 2/8, 1918
20 UNDERTAKER: Potosi J. B. Boyer & Son — ADDRESS: Potosi Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia"(merely symptomatic),"Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

County Washington

Township ______ or Village or City Potassi (NO. ______ St.; ______ Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 881

Primary Registration District No. 4538

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

File No. ______

Registered No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William J. Casey

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE W

SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) S

DATE OF BIRTH ______ (Month) ______ (Day) ______ (Year)

AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ______
(b) General nature of industry, business, or establishment in which employed (or employer) ______

BIRTHPLACE (City or town, State or foreign country) ______

PARENTS
NAME OF FATHER ______
BIRTHPLACE OF FATHER (City or town, State or foreign country) ______
MAIDEN NAME OF MOTHER ______
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ______

(ADDRESS) ______

Filed Apr. 1 191 8. S. T. Thurman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 6, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ______, 191___, to ______, 191___, that I last saw h___ alive on ______, 191___, and that death occurred, on the date stated above, at ______ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Atheromatous Degeneration of Arteries

(Duration) 64 yrs. ______ mos. ______ ds.

Contributory (SECONDARY) ______ (Duration) ______ yrs. ______ mos. ______ ds.

(Signed) D. G. Blount M.D.

Apr. 1, 1918 (Address) Potosi Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL ______

DATE OF BURIAL ______, 191___

UNDERTAKER ______

ADDRESS ______

Original file, date ______, 19___ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

762 4.

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