No. 2
11-10-39
5-17-39
FILED MAY 13 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14951

Registration District No. 318 — Primary Registration District No. 5440 — Registrar's No. 333

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

1. PLACE OF DEATH:

(a) County GREENE S. Campbell Z

(b) City or town Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Medical Center for Federal Prisoners, 9
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 2Mo 6 Da. (Specify whether
In this community 2 yrs., 2 mo., 6 days.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County

(c) City or town Hogansburg
(If outside city or town limits write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CASEY, Joseph

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Indian

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) (Day) 1873 (Year)

8. AGE: Years Abt. 67 | Months - | Days - | If less than one day hr. min.

9. Birthplace St. Regis Indian Reservation, N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

FATHER
12. Name Richard Casey
13. Birthplace St. Regis Indian Reser. N.Y.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Tressa Jackson
15. Birthplace St. Regis Indian Reser., N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Deceased.

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/6/40 (Month) (Day) (Year)

(c) Place: burial or cremation Hogansburg, New York

18. (a) Signature of funeral director Alma Lohmeyer

(b) Address Springfield, Mo

19. (a) 4/6/40 (Date received local registrar) (b) Chas. A. George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th year 1940 hour 2:35 minute P. M.

21. I hereby certify that I attended the deceased from December 28, 1937, 19__, to March 4, 1940, 19__; that I last saw him alive on March 4, 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	Unknown
Due to Syphilis	12 yrs.
General Paresis	3 "
Due to Arteriosclerosis, coronary	Unknown
Other conditions Otitis Media (Include pregnancy within 3 months of death)	Unknown

Major findings:
Of operations

Of autopsy Yes, confirmed clinical diagnoses.

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? No (e) Means of injury

23. Signature E.W.Green, USPHS, (M. D. or other)

Address Clinical Director Date signed 4-6-40

(Licensed Embalmer's Statement on Reverse Side)

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 Chas C. George, Registered Apprentice No. 204 working under my personal supervision.

Signed E. O. Northey

Licensed Embalmer No. 1767

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.