

V. S. No. 2
DOM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

705911
25631
State File No.
Registrar's No. 1569

FILED JUL 31 1944

Registration District No. 379

Primary Registration District No. 6076

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
128 E. ETTA Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 000
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. 4909 a Highland ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNIE CASEY
(b) If veteran, name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 22
year 1944 hour 12 minute 30 P.M.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Single
(b) Name of husband or wife _____
(c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from July 1, 1944 to July 22, 1944
that I last saw him alive on July 22, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

7. Birth date of deceased: April 9 1862
(Month) (Day) (Year)
8. AGE: Years 82 Months 3 Days 13
If less than one day _____ hr. _____ min.

Due to _____
Due to 932
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
Housework

10. Usual occupation _____
11. Industry or business _____
12. Name William Casey
13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Casey
15. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Mrs. Mae Eritz
(b) Address 4909 A Highland ave
17. (a) Burial (b) Date thereof 7/25/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director SULLIVAN BRO'S
(b) Address 2849 N Euclid ave,
JUL 25 1944
19. (a) (Date received local registrar) (b) E. G. Mottarano, MD
(Registrar's signature)

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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other)
Address 7606 Winberry Date signed [Signature]

Dr O. J. MCNEE *Mcnee*
7606 Michigan ave. Hudson 9416

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 *Raymond H. Sullivan*

Licensed Embalmer No. *2930*

P. O. Address *W. H. Sullivan*

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.