

FILED SEP 30 1944

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days) 0

3. (a) PRINT FULL NAME Mamie Irene Cassel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Albert A. Cassel 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased July 2nd, 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Washington, Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name James Lester

13. Birthplace Washington, Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Carroll

15. Birthplace Washington, Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Albert A. Cassel
(b) Address 6815 Nashville Ave.

17. (a) Burial (b) Date thereof 9-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Blvd.

19. (a) SEP 20 1944 (b) J. J. Bede
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6815 Nashville Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18th.
year 1944 hour 9.15 minute _____ P. M.

21. I hereby certify that I attended the deceased from 9/7, 1944, to 9/18, 1944,
that I last saw her alive on 9/18, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 1 hr.
Due to Arteriosclerosis 10 yrs
Due to Diabetes 20 yrs

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Coronary Occlusion
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B. D. Long (M. D. or other) M. D.
Address 1139 Bellevue St. Room 17 Date signed 9/19/44

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

Robert L. Bunkman

Licensed Embalmer No.

3553

P. O. Address

3710 N Grand

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.