

S. No. 2  
4-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1012

FILED FEB 6 1945

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 332

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K 6  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 548 Campbell  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 yrs 1 (Specify whether years, months or days)

3. (a) PRINT FULL NAME FRED CASONE

3. (b) If veteran, name war no 3. (c) Social Security No. 487-10-3845

4. Sex M D 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Terisa 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept 4 1895  
(Month) (Day) (Year)

8. AGE: 49 Years 5 Months 4 Days If less than one day hr. min.

9. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business macaron mfg.

12. Name Joseph Casone

13. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

14. Maiden name Elsa Bianchi

15. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Casone

(b) Address 636 Olive

17. (a) Burial (b) Date thereof 1/23/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt St Marys Cem

18. (a) Signature of funeral director Sebbetos

(b) Address 901 E 5th

19. (a) 1-22-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town K 6 48  
(If outside city or town limits, write "RURAL")  
(d) Street No. 548 Campbell 3  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 18 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10/3/44 19\_\_\_\_ to 1-18-45 19\_\_\_\_; that I last saw him alive on 1-15-45 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial heart disease Duration 1 1/2 yrs  
Chronic gonorrhea - sepsis 2 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions. (Include pregnancy within 3 months of death) 93 d

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury D  
23. Signature John H. Barker (M. D. or other) Chd  
Address 130 Maple Bldg KC Mo Date signed 1-18-45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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**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 \_\_\_\_\_  
*Ray E. Snow*

\_\_\_\_\_  
Licensed Embalmer No. 2560

P. O. Address \_\_\_\_\_  
*B 6 Mo*

**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.**