

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25504

State File No. \_\_\_\_\_  
Registrar's No. 7378

SEP 1 1945

318

Primary Registration District No. 1003

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

60  
17  
9

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:  
4686 Farlin 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

3. (a) PRINT FULL NAME William W. Casey

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Lottie

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased December 10, 1880  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>8</u>	<u>11</u>	hr. _____ min.

9. Birthplace Newberg Indiana /  
(City, town, or county) (State or foreign country)

10. Usual occupation Policeman

11. Industry or business St. Louis Policeman Department

12. Name John Casey

13. Birthplace Indiana /  
(City, town, or county) (State or foreign country)

14. Maiden name Wizzie Moore

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

16. (a) Informant Mrs. Lottie Casey

(b) Address 4686 Farlin Ave.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 8 - 25 - 45  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. H. Stuart

(b) Address 1225 Mason Blvd

19. (a) AUG 24 1945 (Date received local registrar)

(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4686 Farlin Ave.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st  
year 1945 hour 3:10 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from January 10, 1943 to Aug 21, 1945  
that I last saw him alive on Aug 20, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions [Signature]  
\* (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? [Signature] (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]

Address 4126<sup>o</sup> Shreve Date signed 8/22/45

Duration 2 1/2 Yrs.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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

*Albert G. Happs*

Licensed Embalmer No..... *2971*

P. O. Address.....

**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.**