

FILED DEC 26 1947

Registration District No. **27**

Primary Registration District No. **4135**

Registrar's No. **46**

1. PLACE OF DEATH:

- (a) County **Clinton**
- (b) City or town **Gower mo**
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

- (d) Length of stay: **In hospital or institution** (Specify whether)

In this community **2 weeks**
years, months or days

3. (a) PRINT FULL NAME **EVA CASEY**

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

- 4. Sex **FEMALE** / 5. Color or race **white**
- 6. (a) Single, widowed, married, divorced **Married**

- 6. (b) Name of husband or wife **C. E. Casey**
- 6. (c) Age of husband or wife if alive **83** years

- 7. Birth date of deceased **April 14 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	8	7	hr. _____ min. _____

- 9. Birthplace **Buchanan Co mo**
(City, town, or county) (State or foreign country)

- 10. Usual occupation **Housewife**

- 11. Industry or business _____

- MOTHER FATHER
- 12. Name **Red Jordan**
 - 13. Birthplace **N.C.**
(City, town, or county) (State or foreign country)
 - 14. Maiden name **Sara Fouts**
 - 15. Birthplace **N.C.**
(City, town, or county) (State or foreign country)

- 16. (a) Informant **C. E. Casey**
- (b) Address **GOWER mo**

- 17. (a) **Burial** (Burial, cremation, or removal)
- (b) Date thereof **Dec. 13-1947**
(Month) (Day) (Year)
- (c) Place: burial or cremation **Antioch Cem.**

- 18. (a) Signature of funeral director **H. A. Bellino**
- (b) Address **GOWER mo**

- 19. (a) **Dec 15 1947** (Date received local registrar)
- (b) **Emice Chastain** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **mo**
- (b) County **Clinton 25**
- (c) City or town **Gower mo**
(If outside city or town limits, write "RURAL")

- (d) Street No. _____ (If rural, give location)

- (e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month **Dec** day **11th** year **1947** hour **9** minute **15 P.M.**

- 21. I hereby certify that I attended the deceased from **Nov 12 4th** 1947, to **Dec 11th** 1947, that I last saw her alive on **Dec 11th** 1947, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary occlusion Duration 3 1/2 hours

Due to **Cerebral Hemorrhage** 2 months

Due to _____

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

Major findings: Of operations _____

Of autopsy **94A**

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 **?**

- 23. Signature **J. C. Starks mo** (M. D. or other)
- Address **Hawley mo** Date signed **12/12/47**

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

DISTRICT HEALTH OFFICER
Cameron, Mo.

APR 30 1954

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 H. A. Sullivan

Licensed Embalmer No. 1738

P. O. Address Greene 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.