

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3146
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Wash	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS 17	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 6007 CLEMENS AVE	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 6007 Clemens			
3. NAME OF DECEASED a. (First) JOSEPH b. (Middle) T. c. (Last) CASEY			4. DATE OF DEATH (Month) (Day) (Year) APRIL 5-1949
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 31-1875
9. AGE (In years last birthday) 73		10. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPRINKLING FITTER		10b. KIND OF BUSINESS OR INDUSTRY SPRINKLING FITTER	
11. BIRTHPLACE (State or foreign country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME CASEY		13b. MOTHER'S MAIDEN NAME MARY O'NEIL	
14. NAME OF HUSBAND OR WIFE MARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME MRS MARY CASEY		ADDRESS 6007 CLEMENS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis (acute) 9 30 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 11 2 22 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio-Sclerosis Thromb 5 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-4, 1949, to 4-5, 1949, that I last saw the deceased alive on 4-4, 1949, and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Everett J. Jovan MA U		23b. ADDRESS 607 No Grand Blvd	
23c. DATE SIGNED 4/7/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-8-49	
24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) ST LOUIS MO	
DATE REC'D BY LOCAL REG. APR 7		REGISTRAR'S SIGNATURE J. J. Jasater	
5. FUNERAL DIRECTOR'S SIGNATURE Charles Kelly		ADDRESS 4386 Lindell	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *James G. Lemmers*
Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.