

FILED OCT 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34651

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8895

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside appropriate limits, write RURAL and give township)		a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
c. CITY (If outside appropriate limits, write RURAL and give township)		c. CITY (If outside appropriate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS	

3. NAME OF DECEASED (First) <u>Bridget</u>		b. (Middle) <u>Casserly</u>		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Oct. 6-1878</u>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>4</u>	

13a. FATHER'S NAME <u>James Casserly</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Kane</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Samuel Stebbins</u> ADDRESS <u>3946 Cottage</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Rheumatic Heart Disease</u>		DUPLICATE OF (b) <u>Pernicious Anemia</u>		<u>1 year</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c)		<u>3 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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? <u>290.0</u>	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>Oct 19</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>50</u> , and that death occurred at <u>4 A.</u> m., from the causes and on the date stated above.					

23a. SIGNATURE <u>H.O. Schepel, M.D.</u> (Degree or title)		23b. ADDRESS <u>Masonic Shrine Bldg</u>		23c. DATE SIGNED <u>10-20-50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-21-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis</u>	
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DATE REC'D BY LOCAL REG. <u>OCT 20 1950</u>		REGISTRAR'S SIGNATURE <u>J. Blaser</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Chas. F. Strath</u> ADDRESS <u>1225 Union</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Clement Mc Neary

Signed.....
Student Embalmer

Licensed Embalmer No. *3732*

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.