

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **23088**

No. 300
10-48

FILED JUL 15 1952

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **592** Registrar's No. **1205**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Wellston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 1 mo. 6 days		d. STREET ADDRESS (If rural, give location) 1427 So. Ninth Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital		e. STREET ADDRESS 1	

3. NAME OF DECEASED (Type or Print) a. (First) Rev James b. (Middle) J. c. (Last) Cashman			4. DATE OF DEATH (Month) (Day) (Year) 6-22-52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH March 30, 1900		9. AGE (In years last birthday) 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Catholic Priest	11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Cashman	13b. MOTHER'S MAIDEN NAME Elizabeth O'Connor	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Rev. J.W. Stakelum, Superior	ADDRESS 3628 Loughborough
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Years	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease			
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Hypertension			"
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 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 5-16-1952, to 6-22-1952, that I last saw the deceased alive on 6-22-1952, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE J. A. Costello, M.D. (Degree or title)	23b. ADDRESS 2407 N. Blvway St. Louis 6	23c. DATE SIGNED 6/22/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 25, 1952	24c. NAME OF CEMETERY, OR CREMATORY Community Cemetery	24d. LOCATION (City, town, or county) (State) Perryville, Mo.
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DATE REC'D BY LOCAL REG. 6-23-52	REGISTRAR'S SIGNATURE Hester B. Donke	25. FUNERAL DIRECTOR'S SIGNATURE J. Donnelly	ADDRESS 3840 Lindell Blvd.
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WRITE PLAINLY—USING UNFAADING 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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Wm S. Saper

Licensed Embalmer No. 4699

P. O. Address St Charles, 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.