

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6015**

BIRTH MO. **FILED MAR 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1528**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN ST. LOUIS Mo	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY'S Hosp		e. STREET ADDRESS (If rural, give location) 2 4938 TYROLEAN	

3. NAME OF DECEASED (Type or Print) EDITH BRANDLE CASEY			4. DATE OF DEATH (Month) (Day) (Year) FEB. 13 1954		
a. (First)	b. (Middle)	c. (Last)			

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT 21 1895 68	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME JAMES WRIGHT	13b. MOTHER'S MAIDEN NAME MATHILDA VAUGHN	14. NAME OF HUSBAND OR WIFE JOHN C. CASEY
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME JOHN C. CASEY	ADDRESS 4938 TYROLEAN
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma			1 yr
ANTECEDENT CAUSES	DUE TO (b)		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c)		
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"/>
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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? 170X

22. I hereby certify that I attended the deceased from **Feb. 7, 1954** to **Feb. 13, 1954** that I last saw the deceased alive on **Feb. 13, 1954**, and that death occurred at **7:30 PM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. D. J. Johnson M.D.	23b. ADDRESS 6400 Morganford	23c. DATE SIGNED 2-15-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE FEB. 17 1954	24c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEM.	24d. LOCATION (City, town, or county) (State) BELLEVILLE ILL.
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DATE REC'D BY LOCAL REG. FEB 16 1954	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 296 Garwood
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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..

Student.....
Signature of Student Embalmer

Signed..... *Leo J. Budde*
Licensed Embalmer No. *39*
P. O. Address..... *H. L.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.