

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

1003

State File No. **20300**
Registrar's No. **5236**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				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 St. Louis <input type="radio"/>		c. LENGTH OF STAY (In this place) 2 M 9 D		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital				e. STREET ADDRESS (If rural, give location) 5263 Gilmore			
3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL		b. (Middle) _____		c. (Last) CASEY		4. DATE OF DEATH (Month) (Day) (Year) June 10 1954	
5. SEX Male <input type="radio"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 5, 1875	
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman			10b. KIND OF BUSINESS OR INDUSTRY Firefighting		11. BIRTHPLACE (City and State or Foreign Country) Missouri, St. Louis, Mo. <input type="radio"/>		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Michael Casey			13b. MOTHER'S MAIDEN NAME Mary O'Neill		14. NAME OF HUSBAND OR WIFE Katherine Casey		
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 ADDRESS Katherine Casey 5263 Gilmore Ave.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Gen. Arteriosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH years years
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE _____		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? 4200			
22. I hereby certify that I attended the deceased from Apr. 1, 1954 , to June 10, 1954 , that I last saw the deceased alive on June 10, 1954 , and that death occurred at 6:15 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Loyle Esker M.D.				23b. ADDRESS 5600 Arsenal St.		23c. DATE SIGNED 6 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6-12-54		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. JUN 11 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's		ADDRESS 2849 N. Euclid Ave.	

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..... *Albert Mayfield*
Licensed Embalmer No..... 307

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.