

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13193**
3069

FILED APR 18 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 3967 Cook Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) H. c. (Last) Caswell Jr.	4. DATE OF DEATH (Month) (Day) (Year) April 3, 1955
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unk.	8. DATE OF BIRTH Nov. 20, 1907	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months 4 Days 14	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY Rubbish Coll.	11. BIRTHPLACE (City and State or Foreign Country) Morceline, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William H. Caswell	13b. MOTHER'S MAIDEN NAME Missouri Ana Carter	14. NAME OF HUSBAND OR WIFE Alfreda Caswell
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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) No	16. SOCIAL SECURITY NO. 495-05-9762	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James E. Caswell 4150 Enright
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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, asthma, 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) Infected decubitus ulcers. Pulmonary Edema and Congestion following injuries suffered around Jan. 28, 1955 DUE TO (b) Exact time, place, cause and character of same could not be determined DUE TO (c) Accident		
	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 Accident	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis (Mo.)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) Jan 28 5 15 p.m.	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E9049
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased _____, 19____, and that death occurred at **5:30 A.M.**, from the causes and on the date stated above. **45**

23. SIGNATURE Wm. Smith M.D. (Doctor or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 4/6/55
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24. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/6/55	24c. NAME OF CEMETERY OR CREMATORY Oakedale Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. APR 6 1955	REGISTRAR'S SIGNATURE Wm. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Smith 4019 Washington
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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
Student Embalmer

Signed _____

Licensed Embalmer No. 2377

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.