

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9790

STATE FILE NUMBER

FILED APR 9 - 1957

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 111

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Francis 0941</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre 0</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Peters 11008</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp. 2 days</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>1067 N. Water St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Clea Mae Casey</u>			4. DATE OF DEATH <u>April 1 1957</u> Month Day Year
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23 1886</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>na</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Miller Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>		13. FATHER'S NAME <u>John Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Mc Slathon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Bertha Barry St. Louis Mo</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			before hosp admission
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>3/30/57</u> to <u>4/1/57</u> and last saw her ^{her} alive on <u>4/1/57</u> Death occurred at <u>10:35 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. W. Fuller MD</u>		22b. ADDRESS <u>Bonne Terre, Missouri</u>	
22c. DATE SIGNED <u>4/2/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-3-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>Mr. Luther Sparks Peters</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Apr. 2, 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Murphy L. Spink*.....

Licensed Embalmer No. *425*.....

P. O. Address *of La Rue*.....

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.