

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014739

STATE FILE NUMBER

FILED VS APR 18 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 82

INDEXED

|   |  |   |  |   |  |  |  |                                    |  |
|---|--|---|--|---|--|--|--|------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Franklin</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Franklin</b> b. COUNTY <b>Missouri</b> |  |  |  |                                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Washington</b>  |  | Length of stay in 1b  |  | c. CITY OR TOWN <b>Lonedell</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |                                    |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Francis Hosp.</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>Rural</b>                |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Catherine</b> Middle Last <b>Casey</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>10</b> Year <b>1960</b>   |  |  |  |                                    |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Mar 3, 1885</b>  | 9. AGE (last birthday)<br><b>75</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR   |                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>          |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |                                    |  |
| 13a. FATHER'S NAME<br><b>Frank Tolton</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Winnie Hedger</b>                                    |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Arthur Casey</b>                                   |  |                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br>Address<br><b>Mae Chisum St. Clair, Mo.</b>                 |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive pneumonitis</b><br>DUE TO (b) <b>Right Cerebral vascular thrombosis</b><br>DUE TO (c) <b>Cerebral Arteriosclerosis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b><br><b>7 hrs.</b><br><b>unknown</b>  |                                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Chronic Bronchial Asthma, Generalized Arteriosclerosis</b>  |  |   |  |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                    |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |  |   |  |  |  |                                    |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>4/7/60</b> to <b>4/10/60</b> and last saw her/him alive on <b>4/10/60</b><br>Death occurred at <b>6:30</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |   |  |  |  |                                    |  |
| 22a. SIGNATURE (Degree or title)<br><b>Samuel P. Boyer M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>2nd &amp; Elm Washington Mo</b>  |  |  |  | 22c. DATE SIGNED<br><b>4/12/60</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>April 13, 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Luebbering</b>                              |   | 23d. LOCATION (City, town, or county) (State)<br><b>Luebbering, Missouri</b> |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>Casey Lenox</b><br>ADDRESS<br><b>St. Clair, Mo.</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>4/14/60</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>J.P. Schumann &amp; P. Schumann</b>                  |  |                                    |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *L. M. Leroy*

Licensed Embalmer No. 3601

P. O. Address St. Clair, La.

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.