

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011755

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 54

FILED MAR 16 1962											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Lawrence County</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Aurora Community Hospital</u></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u></p> <p>c. CITY OR TOWN <u>Marionville</u></p> <p>d. STREET ADDRESS (If outside, give location) <u>E. O'Dell Street</u></p>										
<p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;">First Middle Last <u>Joseph Taylor Casper</u></p>											
<p>4. DATE OF DEATH</p> <p style="text-align: center;">Month Day Year <u>March 10, 1962</u></p>											
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>June 4, 1894</u></p>	<p>9. AGE (last birthday) <u>67</u></p>	<p>IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u></p>	<p>IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u></p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor of Dentistry</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Queen City, Missouri</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U S A</u></p>					
<p>13a. FATHER'S NAME <u>Joseph Taylor Casper</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>Anna Hays</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Marian Casper</u></p>						
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u></p>			<p>16. SOCIAL SECURITY NO. <u>[REDACTED]</u></p>		<p>17. INFORMANT Address <u>Mrs. J. T. Casper, Marionville, Missouri.</u></p>						
<p>18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u></p> <p style="text-align: center;">DUE TO (b) <u>Atherosclerosis</u></p> <p style="text-align: center;">DUE TO (c) <u>  </u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>hrs.</u></p>					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>					<p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>						
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>							
<p>20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>					
<p>21. I attended the deceased from <u>3:00 AM</u> to <u>5:35 AM</u> and last saw her/him alive on <u>3/10/62</u> Death occurred at <u>5:35 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>						<p>22a. SIGNATURE (Degree or title) <u>William J. Hamilton MD</u></p>		<p>22b. ADDRESS <u>Aurora Mo</u></p>		<p>22c. DATE SIGNED <u>3/12/62</u> (State)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p>		<p>23b. DATE <u>March 11, 1962</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) <u>Topeka, Kansas.</u></p>					
<p>24. FUNERAL DIRECTOR ADDRESS <u>Bradford-SurrIDGE, Marionville, Missouri</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>3-11-62</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>George Langley</u> <u>per G. Phillips</u></p>						

VS 300  
Rev. 4/59

10551

20550

3

4 0

5 1

6

7 0

8 2

94201

10

11

121-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

MAR 20 1962

APR 4 1963

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 William A. Fules

Licensed Embalmer No. 4658  
P. O. Address Marionville

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.

Received March 11, 1962  
Signature  
Pending