

REC'D MAY 18 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14578
Do not use this space.

1. PLACE OF DEATH
 (a) County Franklin Registration District No. 1104
 (b) Township Boon Primary Registration District No. 5415C
 (c) City (d) Street No. Registered No. 9
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 2. PRINT FULL NAME Joseph Posey 200
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Posey (De)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25 1866
 7. AGE YEARS 72 MONTHS 1 DAYS 3 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Ex Soldier
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mt Carmel Ill
 13. NAME J W Posey
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 15. MAIDEN NAME Permelina Hank
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 17. INFORMANT (ADDRESS) Everlyn Powers
 18. BURIAL, CREMATION, OR REMOVAL PLACE Leslie, Mo DATE April 30 1938
 19. FUNERAL DIRECTOR (ADDRESS) W. J. Johnson
Beaufort Mo
 20. FILED 19 Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28 1938
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at 6 P.M.
 The principal cause of death and related causes of importance were as follows:
Auto Accident
Fracture Skull
 Date of onset 210
 Other contributory causes of importance:
Lost control of car
no one at wheel
 Name of operation none Date of
 What test confirmed diagnosis? Crowe Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 19.....
 Where did injury occur? Highway 50 at Leslie
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury Auto accident
 Nature of injury Fracture Skull
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) W. P. Shaffer Crowe
 (Address) Sullivan Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

STATEMENT BY LICENSED EMBALMER

I, E H Terrence, Licensed Embalmer No. 3076

hereby certify that the body recorded on the reverse side of this certificate was embalmed by E H Terrence

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed E H Terrence

Licensed Embalmer No. 3076

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Franklin Registration District No. 1104
 (b) Township Bourne Primary Registration District No. 54-13- Registered No. 9
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Casey

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Casey (nee)
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25-1866
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 1 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Ex Soldier
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 28, 1938
 22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
 I last saw h... alive on... 19... Death is said to have occurred on the date stated above, at 6 P.M.
 The principal cause of death and related causes of importance were as follows:
auto accident fractured skull
 Date of onset 2:15 PM
 Other contributory causes of importance:
lost control of car no one at fault.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mt Caramel Ind

FATHER 13. NAME L. W. Casey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Permelina Hank

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Eugene Powers

18. BURIAL, CREMATION, OR REMOVAL PLACE Lake mo DATE apr 30 1938

FUNERAL DIRECTOR (ADDRESS) E. H. Thompson

20. FILED 4-19 1938 Charles A Schmidt Local Registrar.

Name of operation none Date of...
 What test confirmed diagnosis? none Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide accident Date of injury... 19...
 Where did injury occur? Highway 3.0 st Leola
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Public Highway
 Manner of injury auto accident
 Nature of injury fractured skull

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) Thas J. Shaffer coroner
 (Address) Sullivan mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCURRANCE is very important.

