

No. 2
5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22852

State File No.

FILED AUG 8 1944 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 6791

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2650 Franklin Ave. (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Robert Leslie Casey Twin #1

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or Race Negro 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased. 6 17 43
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name Pearline Casey
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Mays Sherard, R.N.

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof JUL 20 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. Muschler

(b) Address City Health Dept

19. (a) 1944 (b) 7-23-43
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23
year 43 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from 6 - 17 19 43 to 6 - 23 19 43
that I last saw him alive on 6 - 23 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration
Unknown

Due to Unknown
Due to Unknown / 57

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature W. Simley (M. D. or other) 7-23-43
Address 2601 N. Whittier St. Date signed.....

WRITE PLAINLY—USE 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.