

No. 2
1-5-43
5-17-39
I X36671

FILED APR 27 1945
Registration District No. 318

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary Infirmiry Hospital. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Days
(Specify whether _____)

In this community 28 Years
(years, months or days)

3. (a) PRINT FULL NAME Blanche Beard Casey.

3. (b) If veteran, name war no

3. (c) Social Security No. no card

4. Sex Female } 5. Color or race Col.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edward Casey

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased May 15, 1899
(Month) (Day) (Year)

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

45	II	4	hr. min.
----	----	---	----------

9. Birthplace St. Charlie Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Irvin Woods

13. Birthplace St. Charlie Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Madge Savington

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Madge Woods

(b) Address 1016 Pines St. St. Charlie Mo.

17. (a) Burial (b) Date thereof April 25, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Wright's Funeral Home
(b) Address 3100 Easton Ave.

19. (a) APR 20 1945 (b) J. P. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 908 N. Ewing Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 th
year 1945 hour 3.10 minute 0 M.

21. I hereby certify that I attended the deceased from April 6
1945 to April 19 1945
that I last saw her alive on April 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Generalized Peritonitis 3 days

Due to Perforated Appendicitis and

Due to Tubo-ovarian Abscess

Other conditions 139 a
(Include pregnancy within 3 months of death)

Major findings: Tubo-ovarian Abscess
Of operations Appendiceal Abscess, Adhesions
Of autopsy _____

Duration

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? _____

23. Signature [Signature] (M. D. or other) _____
While at work? _____ (Specify type of place) (e) Means of injury _____
Address 1111 E. [Signature] Date signed _____

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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address. *1154 Bayard.*

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.