

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1946

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34997
Registrar's No. 9244

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5861 Cates Avenue, /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life Time (Specify whether
In this community Life Time (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mary Casey,
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Ambrose Casey 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 24, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 9 2 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Cavanagh
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Hope
15. Birthplace St. Genevieve, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Vatterott,
(b) Address 8577 Colonial Lane

17. (a) Burial (b) Date thereof Oct. 30, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Collier's Funeral Home
(b) Address 10123 St. Charles Road

19. (a) OCT 29 1946 (Date received by local registrar)
J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5861 Cates Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 26,
year 1946 hour 10:00 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from near
2 1945 to Oct 26 1946
that I last saw h. u alive on Oct 26 1946
and that death occurred on the date and hour stated above.

Immediate cause of death.	Duration
<u>Cerebral Hem.</u>	<u>2 wks</u>
<u>My peritonium</u>	<u>6 mo</u>
<u>Artery Sclerosis</u>	<u>2 yrs</u>

Other conditions (include pregnancy within 3 months of death) _____
Major findings: g3
Of operations _____
Of autopsy _____

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 Leo J. Reilly (M. D. or other) MD
Address 8105 Post Blvd Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

33010

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

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

10123 St. Charles Rd

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.