

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36625

State File No. _____

BIRTH NO. 124 REG. DIST. NO. 419 PRIMARY REG. DIST. NO. 419 Registrar's No. 42

22
0
0
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>CHRISTIAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CHRISTIAN</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>OZARK</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>"RURAL" LEAD HILL</u>	
c. LENGTH OF STAY (In this place) <u>6 DAYS</u>		d. STREET ADDRESS (If rural: give location) <u>CHADWICK ROUTE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HAGUEWOOD HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>BENJAMIN</u> b. (Middle) <u>NONE</u> c. (Last) <u>CASEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 5 1949</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>26 JULY 1876</u>		9. AGE (In years last birthday) <u>73</u>		10. F UNDER 1 YEAR (Months) (Days) (Hours) (Mins.) <u>3 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>WILLIAM COLOMBUS CASEY</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY ANN WALL</u>		14. NAME OF HUSBAND OR WIFE <u>SARAH ELLEN ROBERTS, CASEY</u>	
--	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Oren Casey</u> ADDRESS <u>CHADWICK, MO.</u>	
--	--	-------------------------------------	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis, generalized, severe</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs. known</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>☉</u>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 30 Oct, 1949, to 5 Nov, 1949, that I last saw the deceased alive on 5 Nov, 1949, and that death occurred at 1:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. S. Draper M.D.</u> (Degree or title)		23b. ADDRESS <u>Ozark, Mo</u>		23c. DATE SIGNED <u>7 Nov '49</u>	
---	--	-------------------------------	--	-----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>11-7-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OLD BOSTON CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>CHRISTIAN CO. MISSOURI</u>	
---	--	----------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <u>Nov. 10 1949</u>		REGISTRAR'S SIGNATURE <u>Lutella Leonard</u>		59		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Dean Harris</u> ADDRESS <u>CLEVER, MO.</u>	
--	--	--	--	----	--	---	--

RECEIVED NOV 15 1949
District Health Office No. 6,
District File Number 1149-1163
Date Filed 11-15-49

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. 356

working under my personal supervision.

Student Norman S. Thompson
Student Embalmer

Signed John Dean Harris

Licensed Embalmer No. 4390

P. O. Address Clever, Mo.

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.