

FILED JUN 9 1950  
STANDARD CERTIFICATE OF DEATH

THE DIVISION OF HEALTH OF MISSOURI

State File No. 4809  
Registrar's No. 4809

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS	
c. LENGTH OF STAY (in this place)		2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 23 311 SIDNEY ST.	

3. NAME OF DECEASED (Type or Print) a. (First) Ferdinand b. (Middle) c. (Last) Casimere			4. DATE OF DEATH (Month) (Day) (Year) May 29 1950
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5. SEX M	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR. 8 1894	9. AGE (in years last birthday) 56	10. MONTHS 56	11. DAYS 21	12. HOURS 21	13. MINUTES
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY HIDE CO.	11. BIRTHPLACE (State or foreign country) La.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME DORA CARTER	14. NAME OF HUSBAND OR WIFE SEMONIA CASIMERE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Somonnia Casimere	18. ADDRESS 311 Sidney
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 203X
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22. I hereby certify that I attended the deceased from 5-2, 1950, to 5-29, 1950, that I last saw the deceased alive on 5-29, 1950, and that death occurred at 5:20a m., from the causes and on the date stated above.

23a. SIGNATURE Herbert Kerwin M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 5-29-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) 1)	24b. DATE 6-1-50	24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM.	24d. LOCATION (City, town, or county) (State) WILSTON MO
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DATE REC'D BY LOCAL REG. MAY 31 1950	REGISTRAR'S SIGNATURE J. B. Leasater	25. FUNERAL DIRECTOR'S SIGNATURE A. F. Walton	ADDRESS 2707 Stoddard
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*Name*

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Arthur R. Hollard*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4049 St Ferdinand*

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.