

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24637  
6211  
Registrar's No.

112754

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1005

|   |  |  |  |   |  |                                  |  |
|---|--|--|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE<br>Missouri  |  | b. COUNTY   |  |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br>St. Louis, Mo.   |  | c. LENGTH OF STAY (In this place)  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br>St. Louis 2259 |  |                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>St. Louis City Hospital #1.  |  | d. STREET ADDRESS (If rural, give location)<br>116 N. 8th St.  |  | 0   |  |                                  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First)<br>LEO  |  | b. (Middle)<br>CASSIDY   |  | c. (Last)<br>CASSIDY  |  |                                  |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br>July 17th, 1950  |  | 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White   |  |                                  |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Divorced 3  |  | 8. DATE OF BIRTH<br>Nov. 30, 1901  |  | 9. AGE (In years last birthday) 49<br># UNDER 1 YEAR Months Days<br># UNDER 24 HRS. Hours Min.    |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Shoe Worker  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Lowiston, Mass.                                      |  |                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 13a. FATHER'S NAME<br>Terence Cassidy  |  | 13b. MOTHER'S MAIDEN NAME<br>Julia Marnell  |  |                                  |  |
| 14. NAME OF HUSBAND OR WIFE<br>Margaret Cassidy   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>Unknown  |  |                                  |  |
| 17. INFORMANT'S SIGNATURE OR NAME<br>Josephine Cassidy,   |  | ADDRESS  |  |   |  |                                  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary of Siver</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR?<br>581.1   |  |                                  |  |
| 22. I hereby certify that I attended the deceased from 7/2/50, 19, to 7/17/50, 19, that I last saw the deceased alive on 7/17/50, 19, and that death occurred at 4:25 AM, from the causes and on the date stated above.       |  |  |  |   |  |                                  |  |
| 23a. SIGNATURE<br><u>James A. Hutchinson, M.D.</u>  |  | (Degree or title)  |  | 23b. ADDRESS<br>1515 Lafayette Ave.,  |  |                                  |  |
| 23c. DATE SIGNED<br>7/17/50   |  | 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal 4   |  | 24b. DATE<br>7-19-50  |  |                                  |  |
| 24c. NAME OF CEMETERY OR CREMATORY  |  | 24d. LOCATION (City, town, or county) (State)<br>Lowell, Mass.   |  |   |  |                                  |  |
| DATE REC'D BY LOCAL REG.<br>7-19-50   |  | REGISTRAR'S SIGNATURE<br><u>J. B. Santer</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br>Albert H. Hoppe, 4700 Washington Blvd.                        |  |                                  |  |

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

6217

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 Me

working under my personal supervision.

Student Embalmer No. ....

Signed Elliott H. Remelius

Signed.....  
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.