

FILED SEP 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29488

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 967		
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clinton				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 10 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gower		0257		
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hospital				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) Charles E. Casey			a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1951		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		8. DATE OF BIRTH Aug. 16, 1864		
9. AGE (In years last birthday) 87		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Clinton Co. Mo.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John E. Casey		13b. MOTHER'S MAIDEN NAME Emma Moore		14. NAME OF HUSBAND OR WIFE Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edna H. Holihan, St. Joseph, Mo.				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left lobar pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage DUE TO (c) Arterio sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 1 week 10 days Unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 490x				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)		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 9-9-51, 19, to 9-18-51, 19, that I last saw the deceased alive on 9-17-51, 19, and that death occurred at 5:30 a.m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) John H. Murray M.D.				23b. ADDRESS St. Joseph, Mo.		23c. DATE SIGNED 9/19/51		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 9/20/51		24c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery		24d. LOCATION (City, town, or county) (State) Gower, Mo.		
DATE REC'D BY LOCAL REG. Sept. 21, 1951		REGISTRAR'S SIGNATURE Carl C. East		25. FUNERAL DIRECTOR'S SIGNATURE John H. Murray		ADDRESS Gower, Mo.		

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

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

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John H. Murray

Licensed Embalmer No. 2893

P. O. Address Gower 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.