

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 31 1952

BIRTH NO. _____		REG. DIST. NO. <u>113</u>		PRIMARY REG. DIST. NO. <u>4185</u>		Registrar's No. <u>1-1952</u>		
1. PLACE OF DEATH a. COUNTY Franklin				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Clair		c. LENGTH OF STAY (in this place) 15 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Clair				
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) Charles			a. (First) Charles		b. (Middle) A		c. (Last) Casebolt.	
4. DATE OF DEATH		(Month) 1		(Day) 12		(Year) 52		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 20 Sept. 1887		
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Jobe Casebolt			13b. MOTHER'S MAIDEN NAME Mary Daisy			14. NAME OF HUSBAND OR WIFE Alice Casebolt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 314-48-6683		17. INFORMANT'S SIGNATURE OR NAME Alice Casebolt		ADDRESS St. Clair, Mo.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGESTION HEART FAILURE		DUE TO (b) PULMONARY T.B.					1 1/2 yrs	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) BRONCHITIS					4 YEARS	
II. OTHER SIGNIFICANT CONDITIONS HAS HAD MANY HEMORRAGIC STROKE THE PAST FEW YEARS							4 YEARS	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 002X					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 6-10 , 19 51 , to 1-12 , 19 52 that I last saw the deceased alive on 1-12 , 19 52 and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE John H. P... M.D.				23b. ADDRESS St. Clair Mo.		23c. DATE SIGNED 1-15-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-16-52		24c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks Nat'l		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. 1-16-1952		REGISTRAR'S SIGNATURE E. L. Worthington			25. FUNERAL DIRECTOR'S SIGNATURE St. Clair Mo		ADDRESS	

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

APR 1 1957

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. _____

working under my personal supervision.

Student
Student Embalmer

Signed *R. M. Lewis*

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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.