

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22766**
5684

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS c. LENGTH OF STAY (in this place) 1 day		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Potosi 1100	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Leah b. (Middle) Dorothy c. (Last) Casey			4. DATE OF DEATH (Month) (Day) (Year) 6 6 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-21-1898	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 2 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) Potosi, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Thomas S. White		13b. MOTHER'S MAIDEN NAME Rebecca Casey		14. NAME OF HUSBAND OR WIFE Albert R. Casey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs Rebecca White ADDRESS Potosi, Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Subarachnoid Hemorrhage		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 day	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage		DUE TO (b) Hypertensive Vascular Disease	
*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)	
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 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR 443 X	

22: I hereby certify that I attended the deceased from **6-5-1953** to **6-6-1953**, that I last saw the deceased alive on **6-6-1953** and that death occurred at **2:00 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Carl J. Keis M.D. (Degree or title)		23b. ADDRESS 18 S. Knighthead		23c. DATE SIGNED 6-8-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-9-1953		24c. NAME OF CEMETERY OR CREMATORY ST JAMES CEMETERY	
				24d. LOCATION (City, town, or county) (State) POTOSI Mo	

25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith ADDRESS POTOSI, MO		25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith ADDRESS POTOSI, MO	
DATE REC'D BY LOCAL REG. JUN 8 1953		REGISTRAR'S SIGNATURE J. Carl Smith	

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 Mary M. Smith

Licensed Embalmer No. 4394

P. O. Address. Potosi, 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.