

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

399

FILED JAN 16 1956

State File No. _____
Registrar's No. 96

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>300.7</u>		State File No. _____		Registrar's No. <u>96</u>	
1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>					
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Poplar Bluff, Mo.</u>			c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Poplar Bluff</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Poplar Bluff Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>Route #3</u>		<u>0120 / 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Aline</u>			b. (Middle) <u>Bernice</u>		c. (Last) <u>Casey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 4, 1956</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 4, 1904</u>		9. AGE (In years) (last birthday) Months Days <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Poplar Bluff, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Wm. Berry</u>			13b. MOTHER'S MAIDEN NAME <u>Maggie Frye</u>			14. NAME OF HUSBAND OR WIFE <u>Wm. Casey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm. Casey Poplar Bluff, Mo.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Multiple tumors of liver and colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>and colon</u> DUE TO (c) <u>Probably Malignant.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1561</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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 <u>30 Dec, 1955</u> , to <u>4 Jan, 1956</u> , that I last saw the deceased alive on <u>4 Jan, 1956</u> , and that death occurred at <u>7:30P m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>321 Col. Poplar Bluff, Mo.</u>			23c. DATE SIGNED <u>8 Jan 56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-7-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>		24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>1/10/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frank-Cotrell Poplar Bluff, Mo.</u>				

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

RECEIVED
JAN 17 1956 JAN 12 1956

BUTLER CO. HEALTH CENTER

FILE No. _____

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 _____
Signature of Student Embalmer

Signed Wallace R Knight

Licensed Embalmer No. 451

P. O. Address 412 Vine
Providence

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.