

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33326

STATE FILE NUMBER

FILED SEP 17 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8239

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS 3931 Cleveland Ave.	
3. NAME OF DECEASED (Type or print) First Helen Middle Casey Last Casey		4. DATE OF DEATH Month Day Year Sept. 3, 1957	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steno. Mo. Pacific R.R.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years of last birthday) 51
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Denis J. Casey		13b. MOTHER'S MAIDEN NAME Nellie T. Ryan	
14. NAME OF HUSBAND OR WIFE		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.		17. INFORMANT Address Rev. William Casey, 1427 So. 9th. Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach (Leontis Plastica type)		INTERVAL BETWEEN ONSET AND DEATH Prolongate	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151x	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE		21. I attended the deceased from Death occurred at January 21-57 to 9/13/57 and last saw her alive on 9/2/57 4 am. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) J. Wm. Thompson M.D.		22b. ADDRESS 4952 Maryland 9-3-57	
22c. DATE SIGNED 9/3/57		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Sept. 6, 1957		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3040 Lindell Blvd.	
25. DATE RECD. BY LOCAL REG. sep 3 57		26. REGISTRAR'S SIGNATURE Carl Smith MD mjb	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

