

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010527
STATE FILE NUMBER

FILED MAR 27 1958

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 33

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Lexington</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Odessa</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial</u> | | | Length of stay in lb <u>21 da</u> | | | d. STREET ADDRESS (If outside, give location) <u>8 miles S.E. Odessa</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Wylie</u> Last <u>Caskey</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1958</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 7, 1884</u> | | 9. AGE (In years last birthday) <u>73</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype operator</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u> | | 11. BIRTHPLACE (City and state or country) <u>Sioux Falls, S. Dakota</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Alexander L. Caskey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Elizabeth Van Doren</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>495-05-6592</u> | | 17. INFORMANT <u>Mrs Herbert Caskey, Odessa, Mo.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Bilateral Bronchopneumonia & Interlobar Hemorrhage</u> | | | | | | | 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.) <u>2</u> | | | | |
| 20c. TIME OF INJURY Hour _____ 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 <u>2-22-58</u> to <u>3-18-58</u> and last saw him alive on <u>3-18-58</u> Death occurred at <u>3:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Cecil L. Watson MD</u> | | | | 22b. ADDRESS <u>Odessa, Mo.</u> | | 22c. DATE SIGNED <u>3-20-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE <u>Mar. 21, -58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u> | | 23d. LOCATION (City, town, or county) (State) <u>Odessa, Lafayette, Mo.</u> | | |
| 24. FUNERAL DIRECTOR <u>Ralph O. Jones</u> | | | ADDRESS <u>Odessa, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>21 March 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Wm. S. G. [Signature]</u> |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be stated. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

156-0

VS JUN 15 1959

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.....
Ralph O Jones

Licensed Embalmer No. 46

P. O. Address Odessa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.