

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015639

STATE FILE NUMBER

FILED MAY 8 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4386

300

4-57

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Doctor, Physician, etc. must use only standard nomenclature in Part 18. All diseases in Part 1 must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>New Faith Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>5512 Delmar</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond L. Casey</b>			4. DATE OF DEATH Month Day Year <b>April 20, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August, 24, 1893</b>		9. AGE (In years last birthday) <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Electrical Supplies</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical Supplies</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Casey</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Noonan</b>	
14. NAME OF HUSBAND OR WIFE <b>Julia</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <b>Yes W. W. # 7</b>		16. SOCIAL SECURITY NO. <b>497-67-3520A</b>	
17. INFORMANT <b>Julia Casey, 5512 Delmar, Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Brain Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive Cardiac acc. Arteriosclerosis</b> DUE TO (c) <b>Carcinoma Right Kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>180X</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>---</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>---</b>		20d. INJURY OCCURRED WHILE AT <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.) <b>---</b>	
20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>		20g. COUNTY <b>Missouri</b>		20h. STATE <b>Missouri</b>	
21. I attended the deceased from Death occurred at <b>4/20/58 11 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.		21a. SIGNATURE (Degree or title) <b>Anthony J. Tale M.D.</b>		21b. ADDRESS <b>386 St. Louis Ave</b>	
21c. DATE SIGNED <b>4/21/58</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE <b>4-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		22e. (State)	
23. FUNERAL DIRECTOR <b>Harrigan-Sheahan 4700 Washington, Blvd.</b>		23a. ADDRESS		23b. DATE RECD. BY LOCAL REG. <b>APR 22 '58</b>	
23c. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		23d. (State)		23e. (Signature)	

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 *John S. Derr* .....

Licensed Embalmer No. *9194*  
P. O. Address *St. Louis*

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.