

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030243  
STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7602

**1. PLACE OF DEATH**  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes  No   
TOWN ST LOUIS  
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b  
HOME

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)  
a. STATE MO. b. COUNTY \_\_\_\_\_  
c. CITY OR TOWN St. Louis Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes  No   
5085 MINERVA

**3. NAME OF DECEASED** First Middle Last  
JOSEPHINE CASEY  
4. DATE OF DEATH Month Day Year  
8. 3. 58

5. SEX FEMALE 6. COLOR OR RACE NEGRO 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH 3-4-1885 9. AGE (In years last birthday) 73  
WIDOWED  DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) 12. CITIZEN OF WHAT COUNTRY?  
HOUSE WIFE NONE POTOSI MO U. S. A.

13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Address ELIZABETH WATSON 5085 MINERVA

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Hypertension Cardio-vascular disease  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 443X  
DUE TO (c) \_\_\_\_\_  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
INTERVAL BETWEEN ONSET AND DEATH ?

**19. WAS AUTOPSY PERFORMED?** YES  NO

**20a. ACCIDENT**  **SUICIDE**  **HOMICIDE**  **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)  
**20c. TIME OF INJURY** Hour a. m. Month, Day, Year p. m.  
**20d. INJURY OCCURRED** WHILE AT WORK  NOT WHILE AT WORK  **20e. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.) **20f. CITY, TOWN, OR LOCATION** COUNTY STATE  
7/29/58 8/3/58

**21. I attended the deceased** from 7:30 PM to 8/3/58 and last saw her alive on 8/3/58  
Death occurred at 7:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

**22a. SIGNATURE** (Doctor or title) D. E. Finney **22b. ADDRESS** 3126 Kenilworth **22c. DATE SIGNED** 8/3/58

**23a. BURIAL, CREMATION, REMOVAL (Specify)** REMOVAL **23b. DATE** 8-5-58 **23c. NAME OF CEMETERY OR CREMATORY** POTOSI MO. **23d. LOCATION** (City, town, or county) (State) Potosi, Mo.

**24. FUNERAL DIRECTOR** ADDRESS SWAN UND. CO. 4481 FINNEY **25. DATE RECD. BY LOCAL REG.** AUG 6 '58 **26. REGISTRAR'S SIGNATURE** J. Carl Smith, M.D.  
M. & B.

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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 *Edward A Flynn*.....

Licensed Embalmer No. *444*

P. O. Address *4202 7*

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.