

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037673

STATE FILE NUMBER

1003

FILED OCT 27 1958

Registration District No.

Primary Registration District No.

Registrar's No. 9552

300  
1-57

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>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>University City 4340</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
f. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>7233 Waterman Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JESSAMINE JONES CASSEL</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 5, 1958</b>		
SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1869</b>		9. AGE (In years (In days) <b>89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Rolla, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Dr. T. J. Jones</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown Luster</b>		14. NAME OF HUSBAND OR WIFE <b>Dr. H. F. Cassel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Gertrude O. Cassel 4401 Forest Park Blvd.</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>ARTERIOSCLEROTIC HEART DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>420.0</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).					19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input 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 <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 <b>SEPT. 12, 1958</b> to <b>OCT. 5, 1958</b> and last saw <sup>her</sup> alive on <b>OCT. 5, 1958</b> Death occurred at <b>2:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>C. P. Vermillion, M.D.</b>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>10/6/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-7-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>C. R. Lupton &amp; Sons</b>		ADDRESS <b>7233 Delmar Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 6 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Paul Smith, M.D.</b> <i>m. g. 13</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc., must base only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Arnold W. Schoene

Licensed Embalmer No. 7864

P. O. Address St. Louis, Mo.

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.