

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041662**

**FILED VS NOV 19 1959**

STATE FILE NUMBER

**210293**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>1 Day</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5890 Kennerly Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Hospital</b> Middle <b>Gertrude</b> Last <b>Casey</b>				4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/4/02</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Boulder, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Edwards</b>			13b. MOTHER'S MAIDEN NAME <b>Cora Caster</b>			14. NAME OF HUSBAND OR WIFE <b>Joseph F. Casey</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.		17. INFORMANT Address <b>Mr. Joseph F. Casey, 5890 Kennerly</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>intestinal obstruction</b> DUE TO (b) <b>due to adhesions.</b> DUE TO (c) <b>570.5</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rheumatic Heart Disease</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. _____		Month, Day, Year, _____						
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 <b>Feb 1937</b> to <b>11/8/59</b> and last saw her <u>alive</u> on <b>11/8/59</b> Death occurred at _____ <b>6 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Wm W Weber M.D.</b>				22b. ADDRESS <b>1506 Harrison</b>			22c. DATE SIGNED <b>11/9/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>11/11/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boulder Cemetery</b>		23d. LOCATION (City, town, or county) <b>Boulder</b>		STATE <b>Ill.</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 9 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b> <b>mjb</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1506 Hoddamont Ave.  
Ev 5-9190  
Hr 8. 2-5 Mon.

**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 Warren A. Cave

Licensed Embalmer No. 353

P. O. Address \_\_\_\_\_

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.