

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020770

FILED VS. MAY 18 1960

XC-215706

SL 11700

1003

4869

STATE FILE NUMBER

INDEXED

|   |  |   |  |  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <i>Jefferson</i> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. Grand, St. Louis, Mo.</b>                             |  | Length of stay in 1b<br><b>10 days</b>  |  | c. CITY OR TOWN <b>Kimmswick</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vet. Adm. Hospital</b>                             |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>6 E. Windsor Harbor</b>  |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>V.</b> Last <b>CASSIEDY</b>                                  |  |   |  | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>7</b> Year <b>1960</b>   |  |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8/25/86</b>   | 9. AGE (last birthday)<br><b>73</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bookkeeper</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Jefferson Barracks, Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |
| 13a. FATHER'S NAME<br><b>BARNEY CASSIEDY</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>MARTHA HOPKINS</b>                                   |  | 14. NAME OF HUSBAND OR WIFE<br><b>DOROTHEA LEONA CASSIEDY</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WW-1</b>       |  | 16. SOCIAL SECURITY NO.<br><b>498-01-8813</b>   |  | 17. INFORMANT <b>Kimmswick, Missouri</b><br><b>Dorothea Leona Cassiedy, 6 E. Windsor</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 DAYS</b>                                   |   |
| IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS</b>  |  |   |  |  |  |  |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  |  |  | DUE TO (b) <b>RUPTURED APPENDIX 550.1</b>  |   |
|   |  |   |  |  |  | DUE TO (c) <b>BLOOD IN LARGE BOWEL - NO BLEEDING POINT FOUND</b>                     |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>4/27/60</b> to <b>5/7/60</b> and last saw him alive on <b>5/7/60</b>                          |  | Death occurred at <b>6:40 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                       |  |  |  |  |   |
| 22a. SIGNATURE <i>Hugh M. Foster Jr.</i> (Type or title)<br><b>Hugh M. Foster Jr. M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>VAH, ST. LOUIS, MO.</b>   |  | 22c. DATE SIGNED<br><b>5/7/60</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>May 11, 60</b>         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Jefferson Barracks, MO.</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>Heiligtag--Imperial, Mo.</b>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 9 1960</b>                                    |  | 26. REGISTRAR'S SIGNATURE<br><i>Paul Smith, M.D.</i>   |  |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arthur W. Heilig

Licensed Embalmer No. 3872

P. O. Address Imperial

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.