

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

**-60-024391**

**FILED VS JUL 12 1960**

**318**

Primary Registration District No. **1003**

Registrar's No. **6358**

STATE FILE NUMBER

INDEXED

|  |  |   |  |
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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO</b>                      |  | Length of stay in 1b  | c. CITY OR TOWN <b>ST. LOUIS</b><br>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>3315 - HUMPHREY</b><br>Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) <b>EDWARD</b> Middle <b>CASHEL</b> | 4. DATE OF DEATH <b>JUNE 21, 1960</b> Month Year |
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|                    |                               |  |                                     |                                  |                                |                              |
|--------------------|-------------------------------|--|-------------------------------------|----------------------------------|--------------------------------|------------------------------|
| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>JAN 21 1895</b> | 9. AGE (last birthday) <b>75</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|--------------------|-------------------------------|--|-------------------------------------|----------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SHOE MAN</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GOOD WILL INDST.</b> | 11. BIRTHPLACE (City and state or country)<br><b>PENNSYLVANIA</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
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|   |   |                             |
|---|---|-----------------------------|
| 13a. FATHER'S NAME<br><b>MICHAEL CASHEL</b> | 13b. MOTHER'S MAIDEN NAME<br><b>MARY HARRIS</b> | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>NONE</b> | 17. INFORMANT Address<br><b>JOHN CASHEL 3315 - HUMPHREY</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>420.0H</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Carcinomatosis</b>  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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|---|--|--|---|
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. | 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 |
|---|--|--|---|

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| 21. I attended the deceased from <b>2/15/60</b> to <b>6/21/60</b> and last saw her him alive on <b>6/21/60</b><br>Death occurred at <b>9:10 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <b>Robert W. Moellenhoff M.D.</b> (Degree or title) | 22b. ADDRESS <b>1515 LAFAYETTE AVE</b> | 22c. DATE SIGNED <b>6/21/60</b> |
|--|--|---------------------------------|

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>JUNE 24 1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CALVARY CEM.</b> | 23d. LOCATION (City, town, or county) (State)<br><b>ST. LOUIS MO</b> |
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| 24. FUNERAL DIRECTOR<br><b>Thomas Kute 2906 Gravis</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUN 22 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Loed Smith M.D.</b> |
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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 James O. Hill

Licensed Embalmer No. 4347

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
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.