

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028199

FILED VS JUL 18 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5989** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 15 mo.	c. CITY OR TOWN Webster Groves		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 301 Selma Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Harriett Middle Sutter Last Cassilly			4. DATE OF DEATH Month June Day 10 Year 1960		
5. SEX F	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William John Sutter		13b. MOTHER'S MAIDEN NAME Julia Broking		14. NAME OF HUSBAND OR WIFE Edward J. Cassilly	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Address Edward J. Cassilly, 301 Selma Avenue
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with mitral and tricuspid insufficiency		9 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 4200	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cirrhosis of the liver due to passive congestion	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
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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 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 **May 13, 1952** to **June 10, 1960** and last saw her ^{her} ~~him~~ alive on **June 9, 1960**
Death occurred at **1:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G. O. Brown M.D. - (G.O. Brown, M.D.)	22b. ADDRESS 1325 South Grand Blvd.	22c. DATE SIGNED 6/10/60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE June 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
23d. LOCATION (City, town, or county) St. Louis County, Missouri		(State)

24. FUNERAL DIRECTOR ADDRESS M. J. Croghan, 831 E. Big Bend Blvd. Webster Groves 19, Missouri	25. DATE RECD. BY LOCAL REG. JUN 12 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

mjc

OCT 24 1980

Strasbourg

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

John J. Laine

Licensed Embalmer No. 4108

P. O. Address St. Louis

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