

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046614

FILED VS DEC 21 1960/62

Registration District No. \_\_\_\_\_ Primary Registration District No. 5595 Registrar's No. 134

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>JEFFERSON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WINDSOR HARBOR</b>		Length of stay in lb <b>24 YRS</b>		c. CITY OR TOWN <b>WINDSOR HARBOR</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>IMPERIAL RURAL ROUTE</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>IMPERIAL RURAL ROUTE</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOBOTHEA LEONA CASSIEDY</b>				4. DATE OF DEATH Month Day Year <b>MOV. 25 1960</b>					
5. 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"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 25 1887</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE &amp; NURSE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NURSE</b>		11. BIRTHPLACE (City and state or country) <b>THEBES ILL.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		
13a. FATHER'S NAME <b>SIMON EACHUS</b>			13b. MOTHER'S MAIDEN NAME <b>ANNA SMITH</b>			14. NAME OF HUSBAND OR WIFE <b>JOSEPH (DEC)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>DR. LOUIS MO</b> <b>MRS MAXINE DOSWALD 4912 SUTHERLAND</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>Cerebral Arterial Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arterial sclerosis</b>							<b>1 yr</b>		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterial Sclerotic 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>11/15/60</b> to <b>11/25/60</b> and last saw her <b>alive</b> on <b>11/25/60</b> Death occurred at <b>6:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Charles Burnside M.D.</b>				22b. ADDRESS <b>206 W Argonne Kirkwood 22</b>			22c. DATE SIGNED <b>11/28/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MOV, 29 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>			23d. LOCATION (City, town, or county) <b>JEFFERSON BARRAKS MO</b>			(State)
24. FUNERAL DIRECTOR <b>HEILIGTAG FUNERAL HOME IMPERIAL MO</b>				25. DATE RECD. BY LOCAL REG. <b>11-29-60</b>		26. REGISTRAR'S SIGNATURE <b>Robert E. Bauer</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

MAR 1 1961

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Elmer A. Helbigtag

Licensed Embalmer No. 3571

P. O. Address Imperia

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.