

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
36810
4457
52.5

1. PLACE OF DEATH

County Jackson Registration District No. 399
Towship Kaw Primary Registration District No. 1200
City Kansas City (No. St. Joseph's Hosp)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ethel May Casey
(a) Residence. No. 216 Park Ave St. 9 Ward. _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John D. Casey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 19, 1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
32 10 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri City
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Dennis Stevens

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Anna Monks 11/3, 1918 (Address) Kansas City, Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT John D. Casey
(Address) 216 Park Ave

15. FILED 11/3 28 M M Linn REGISTRAR
ast

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, at Nov 1, 19____, that I last saw her alive on Nov 1, 19____, and that death occurred, on the date stated above, at 2/10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchus Pneumonia

107 95 90 B
(duration) yrs. mos. ds. 3

CONTRIBUTORY Toxic Myocarditis
(SECONDARY) (duration) yrs. mos. ds. 2

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. 216 Park Ave Mo

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) Harry L. Jones, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys DATE OF BURIAL 11-5 1928

20. UNDERTAKER First & Latin Co Linn & Miller ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE IN INK, WITH OUTFADING INK—THIS IS A PERMANENT RECORD

