

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

Do not use this space.

29240

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 6436 Wornall Terr.) St. _____ Ward _____

File No. _____
Registered No. 3413
St. _____ Ward _____

2. FULL NAME Mrs. Catherine E. Casey

(a) Residence, No. 6436 Wornall Terr. St. 8 Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25th 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 74 2 12
8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Michael J. Casey
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calif.

13. NAME Perer Cosgrove
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
15. MAIDEN NAME Catherine Kelly
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Miss Margaret Casey (ADDRESS) 6436 Wornall Terr.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's Cem. DATE 9/10/32 19.

20. FILED 9/9 1932 M. M. Crowe asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 8th. 1932

22. I HEREBY CERTIFY, That I attended deceased from Sept 10 1932 to Sept 8th 1932
I last saw him alive on Sept 8 1932 Death is said to have occurred on the date stated above, at 7.45 Pm.
The principal cause of death and related causes of importance were as follows:

Encephalo-Meningitis
Cerebro-Sclerosis
Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) John H. Skinner, M. D.
(Address) 1402 T 38th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

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J. W. Bryant & Co.
No. 7010