SEP 18 1935

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

Do not use this space.

25646

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 853

City St. Joseph Mo (No. 209 Iowa Ave St. Ward)

2. FULL NAME Harrison Casey

(a) Residence, No. 209 Iowa Ave St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Stella

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 28, 1884 73

7. AGE: YEARS 62 ~~51~~ MONTHS 4 DAYS 16 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cattle Butcher

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Kansas

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs Stella May Casey 209 Iowa Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashland Cem DATE 8-19-35 19

19. UNDERTAKER (ADDRESS) B.F. Graves Funeral Home 806 South 17th St.

20. FILED 8-19- 1935 John A. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 14 35

22. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1935, to Aug 14, 1935

I last saw him alive on Aug 14, 1935. Death is said to have occurred on the date stated above, at 7.45 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Mitral Insufficiency	Several wks ago.
Other contributory causes of importance: Chronic Bronchial Asthma	Several wks ago.

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical. Was there an autopsy? No

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? No

If so, specify .....

(Signed) Fenton Gunderson, M. D.

(Address) 216 N W Mo. Ave

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.