

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

Do not use this space.

36324

1. PLACE OF DEATH **DEC 26 1935**

County Jackson
Township Kaw
City Kansas City (No. 27 E. 33rd St.)

Registration District No. _____
Primary Registration District No. _____

File No. 1552
Registered No. _____
St. _____ Ward _____

2. FULL NAME Mrs. Mary E. Casey

(a) Residence, No. 27 East 33rd Street, St. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV. 29 19 35

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

22. I HEREBY CERTIFY, That I attended deceased from Oct 6 1935, to Nov 29 1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 31 1856

I last saw her alive on Nov 28 1935. Death is said to have occurred on the date stated above, at 1:47^am.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 78 10 28

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

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

Chronic Myocarditis (Insufficiency) Date of onset 1934
AS

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

Other contributory causes of importance:
Nephritis (Glomerular) 11-20-35

13. NAME John Todd

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? NO

15. MAIDEN NAME Unknown

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)

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

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT Mrs. Josephine Manning
(ADDRESS) Lees Summit, Mo.

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE Dec. 2 1935

Nature of injury _____

19. UNDERTAKER Wagner Funeral Home
(ADDRESS) 2047 W. Lincoln

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify _____

20. FILED 11-30 19 35 M. M. Low, Dist
Registrar.

(Signed) Allen F. Nease, M. D.

(Address) 1100 P. of Bldg

~~Professional B. Kelly~~ Feb 27 1946

~~Home~~ 421 W 59 Terrace Hi 6110

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... No. *276 22 rd St*..... St. Ward)

File No.....
Registered No. *4552*
St. Ward)

2. FULL NAME

(a) Residence, No. *Mary E. Casey*..... Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

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).....

13. NAME.....

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

15. MAIDEN NAME.....

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

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL.....

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS).....

20. FILED *11-30* 19 *35* *J. J. Cron* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 29* 19 *35*

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

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

Chronic Myocarditis Date of onset

Other contributory causes of importance:

Refracted
Acute Glomerulonephritis
Cause unknown

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)....., M. D.

(Address).....

SUPPLEMENTARY

OCCUPATION
FATHER
MOTHER

5-36324