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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REG'D JAN 13 1939

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

42035
Do not use this space.

Registered No. 5101

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw 2 — Primary Registration District No. 1002
(c) City or Town Kansas City 1 — (d) Street No. 4204 Olive St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Miss Kate Casey
(a) Residence, No. 4204 Olive St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ----
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 25, 1862
7. AGE: Years 76 | Months 1 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as 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) Louisville, Ky.

FATHER
13. NAME Patrick Casey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
15. MAIDEN NAME Sarah ---- Irish
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Mrs P. J. Burns
(ADDRESS) 3411 Troyer

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Marys Cem. DATE Dec. 31, 1938

19. FUNERAL DIRECTOR (NAME) QUIRK & TOBIN CO.
(ADDRESS) Kansas City, Mo.

20. FILED Dec 30, 1938 M. M. Grove
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 29, 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1938, to Dec 29, 1938
I last saw her alive on Dec 29, 1938. Death is said to have occurred on the date stated above, at 6 9 a.m.
The principal cause of death and related causes of importance were as follows:

Myocarditis — Date of onset ?
about 10 days — 2 3 P

Other contributory causes of importance:
Bronchial asthma — unknown origin

Name of operation ..... Date of .....
What test confirmed diagnosis? observation 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? ..... ?
If so, specify
(Signed) John O. Spencer M. D.
(Address) 1402 Bryant Bldg

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.