

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4815

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community 50 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 710 East 8th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18th
year 1939 hour 5 minute 00 P. M.
21. I hereby certify that I attended the deceased from 12-4-
1939 to 12-18-1939;
that I last saw him alive on 12-18-1939;
and that death occurred on the date and hour stated above.

Immediate cause of death
Adenocarcinoma of rectum with me-
tastases

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature P. F. De Marco M.D. (M.D. 1939)
Address Supt. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

8. (a) PRINT FULL NAME John Cassidy 230

8. (b) If veteran, name war No 8. (c) Social Security No. 423000

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 6 1886
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Professional dancer

11. Industry or business Salt

12. Name John Cassidy

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Marie Wagner (City, town, or county) (State or foreign country)

15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. J. H. Brown

(b) Address 76 Mo

17. (a) Burial (b) Date thereof 12-21-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director J. H. Brown

(b) Address Sumner & Main

19. (a) Dec. 20, 1939 (Date received local registrar) M. M. Brown (Registrar's signature)

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.

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 Maurice Maurik
Licensed Embalmer No. 2226
P. O. Address H.C. Inc

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.