

MAY 15 1940  
Registration District No. 399

Primary Registration District No.

Registrar's No.

1435

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: 4019 Main  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 40 years  
years, months or days

3. (a) PRINT FULL NAME LAWRENCE T. CASSIDY 230  
3. (b) If veteran, name war World War  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Crystal Cassidy  
6. (c) Age of husband or wife If alive 44 years  
7. Birth date of deceased March 31 1900  
(Month) (Day) (Year)

8. AGE: Years 40 Months 0 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Mo  
Retired (City, town, or county) (State or foreign country)

10. Usual occupation Member K.C. Fire Department

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Christopher Cassidy  
13. Birthplace Kansas City MO  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Kennedy  
15. Birthplace Kansas city MO  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edward Cassidy  
(b) Address 2816 West 44th

17. (a) Burial (b) Date thereof 4 2 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. St. Mary's

18. (a) Signature of funeral director W. O. Donnell  
(b) Address 3296 Broadway

19. (a) April 2, 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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. 4019 Main  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1940 hour II minute 50 M.

21. I hereby certify that I attended the deceased from March 1 1937 to March 31 1940  
and that I last saw him alive on March 31 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration \_\_\_\_\_  
Due to Tuberculosis \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged etiologically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide None  
(b) Date of occurrence None  
(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?

23. (a) \_\_\_\_\_ (Specify type of place)  
(b) \_\_\_\_\_ (c) Means of injury  
23. (a) W. O. Donnell (M. D. or other)  
Address 300 Prof. Bldg Date signed 4/2/40

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.

*W. E. Rowe*

**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 *Park G. Rowe*

Licensed Embalmer No. *2347*

P. O. Address *W. E. Rowe*

**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.**