

**FILED JAN 30 1943**

Registration District No. 149 Primary Registration District No. 1002

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:  
Y. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
(Specify whether)

In this community 50 years  
(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. 4036 Troost  
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME THOMAS CASHEN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Anna Cashen

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

7. Birth date of deceased August 26, 1863  
(Month) (Day) (Year)

|         |           |          |           |                      |
|---------|-----------|----------|-----------|----------------------|
| 8. AGE: | Years     | Months   | Days      | If less than one day |
|         | <u>79</u> | <u>4</u> | <u>18</u> | hr. min.             |

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

10. Usual occupation Attendant-K.C. General Hospital

11. Industry or business

12. Name Lawrence Cashen

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

14. Maiden name Burrie Malloy

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

16. (a) Informant Henry Cashen

(b) Address Centertown, Mo.

17. (a) Burial (b) Date thereof Jan. 16, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Thomas E. Quirk Funeral Home

(b) Address 4316 Troost Ave.

19. (a) 1/15/43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14th  
year 1943 hour 10 minute 45 A.M. M.

21. I hereby certify that I attended the deceased from 12-27-42 19..... to 1-14-43 19.....  
that I last saw him alive on 1-14-43 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to Failure

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?.....

(Specify type of place) (e) Means of injury.....

23. Signature Dwight R. Thom (M. D. or other).....  
Address Dir. H. C. Gen. Hospital Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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

*Thomas G. Jewell*

Licensed Embalmer No.....

*3775*

P. O. Address.....

*R. C. M. D.*

**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, fact should be so stated above.**