

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 4 1945
1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15805**
Registrar's No. **2207**

Registration District No. _____ 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: **General Hospital**
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **21 days**
(Specify whether years, months or days) **unknown**

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. **536 1/2 Walnut**
(If rural, give location)
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country _____

3. (a) PRINT FULL NAME **Cassidy, Clyde**
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 **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 27, 1879**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **April** day **23** year **1945** hour **3** minute **50 A.M.**
21. I hereby certify that I attended the deceased from **April 24**, 19**45** to **April 23**, 19**45**.
that I last saw him alive on **April 23**, 19**45**, and that death occurred on the date and hour stated above.

Immediate cause of death **hypertensive cardio vascular disease**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **932**

8. AGE: Years **65-00** Months **9** Days **26** If less than one day hr. min.
9. Birthplace **Vermont** (City, town, or county) (State or foreign country)
10. Usual occupation **none**
11. Industry or business _____
12. Name **William Cassidy**
13. Birthplace **Vermont** (City, town, or county) (State or foreign country)
14. Maiden name **Not known**
15. Birthplace **Not known** (City, town, or county) (State or foreign country)
16. (a) Informant **Record Clerk**
(b) Address **E. C. General Hosp. No. 1**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-23-45** (Month) (Day) (Year)
(c) Place: burial or cremation **Buried**
18. (a) Signature of funeral director **Wm J. [Signature]**
(b) Address **City [Signature]**
19. (a) **5-22-45** (Date received local registrar) (b) **Sheldene Holmes** (Registrar's signature)

Major findings: Of operations _____
Of autopsy _____
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)
While at work? _____ (e) Means of injury _____
23. Signature **Clark W. Seely** (M. D. or other) _____
Address **E. C. General Hospital** Date signed _____

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

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.....

Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Wm. A. [Signature]

Licensed Embalmer No. *3089*

P. O. Address. *NC MD*

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.