

FILED MAR 21 1947
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County... **JACKSON**

(b) City or town... **FAIRBANKS CITY**

(c) Name of hospital or institution: **R. C. OSTEOPATHIC HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 DAYS**
(Specify whether)

In this community **20 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. **1526 CYPRESS**
(If rural, give location)

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

3. (a) PRINT FULL NAME **GERALDINE G. CASEY**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **495-24-3967**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH**, day **4th**, year **1947** hour **5:00** minutes **15** A.M.

21. I hereby certify that I attended the deceased from **3-17-47** to **3-17-47** 19**47**; that I last saw her alive on **3-3-47** 19**47**; and that death occurred on the date and hour stated above.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MR. BEN R. CASEY**

6. (c) Age of husband or wife if alive **23** years

7. Birth date of deceased... **JANUARY 16 1927**
(Month) (Day) (Year)

Immediate cause of death

MENINGEAL AND VASCULAR SYPHILIS & CEREBRAL THROMBOSIS, RESULTING IN RESPIRATORY FAILURE

Due to **THROMBOSIS**

Due to **FAILURE**

Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years **20** Months **1** Days **19** If less than one day hr. min.

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **WILLIAM PERKINS**

13. Birthplace **COLUMBIA MISSOURI**
(City, town, or county) (State or foreign country)

14. Maiden name **LOIS**

15. Birthplace **COLUMBIA MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **Benny R. Casey**

(b) Address **1526 CYPRESS**

17. (a) **BURIAL** (b) Date thereof **MAR 6 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **GREEN LAWN CEMETERY**

18. (a) Signature of funeral director **W. N. Newcomer**

(b) Address **1401 BRUSH CREEK BLVD**

19. (a) **3-6-47** (b) **Geraldine G. Casey**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations **30 C**

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?

23. Signature **Dr. E. J. Penfold** (M.D. or other) **2**

Address **4748 Perfect Rd.** Date signed **3-4-47**

4748 Prospect
1-6

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 Emile W. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. Mo.

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.