

No. 2  
12-45  
17-39  
X47070

FILED JUL 19 1947  
1947

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:  
**611 Brooklyn**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **5 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**  
(c) City or town **Kansas City Mo** **3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **611 Brooklyn** **8**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Elsie May Caselman**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Ernest N. Caselman** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **July 5 1894**  
(Month) (Day) (Year)

8. AGE: Years **53** Months **0** Days **5** If less than one day hr. min.

9. Birthplace **Trenton Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **housewife**

12. Name **Edward Mead**

13. Birthplace **New York**  
(City, town, or county) (State or foreign country)

14. Maiden name **Virginia Hanson**

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

16. (a) Informant **E. N. Caselman**

(b) Address **611 Brooklyn**

17. (a) **burial** (b) Date thereof **7-12-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope, Kansas City**

18. (a) Signature of funeral director **Edo Bred**

(b) Address **1416 Miami**

19. (a) **7-11-47** (b) **Theraldine Holman**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10**  
year **1947** hour **10** minute **PM** M.

21. I hereby certify that I attended the deceased from **May 26**  
**1947 to July 10 1947;**  
that I last saw her alive on **July 10 1947;**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia** *Duration 3 1/2 hrs*

Due to **Cerebral Thrombosis** *6 hrs*

Due to **Cerebral Arteriosclerosis**

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **g3h**

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury **2**

23. Signature **Maurice M. Sleaghty** (M. D. or other) **D.O.**  
Address **6045 E. 15th St.** Date signed **7/11/47**

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

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**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 O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Kan City, Kans.

**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.**