

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 KANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5615 WINNER ROAD  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 30 YEARS  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MR. ROBERT ARCHIBALD CAREY  
 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 MARRIED  
 6. (b) Name of husband or wife MRS. SOPHIA T. CAREY  
 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased AUGUST 8 - 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>10</u>	<u>6</u>	hr. ___ min.

9. Birthplace DOUGLAS COUNTY KANSAS  
(City, town, or county) (State or foreign country)

10. Usual occupation FINISHER - RETIRED

11. Industry or business HOME

12. Name GEORGE W. CAREY

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

14. Maiden name SAMANTHA ROSE GILLILAND

15. Birthplace UNKNOWN KENTUCKY  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS SOPHIA T. CAREY

(b) Address 5615 WINNER ROAD

17. (a) BURIAL (b) Date thereof JUNE 17 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director P. H. Newcomer's Sons

(b) Address KANSAS CITY, MISSOURI

19. (a) 6-16-48 (b) Sheldine Holmes  
(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. 5615 WINNER ROAD  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month JUNE day 14<sup>TH</sup>  
 year 1948 hour 6 minute 15A M  
 21. I hereby certify that I attended the deceased from 2/25/47  
 \_\_\_\_\_, 19\_\_\_\_, to 6/14, 1948  
 that I last saw him live on 6/10  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arricular fibrillation 1 1/2 yrs  
Chr. Myocardiosis 1 1/2 yrs

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

Major findings:  
 Of operations 93  
 Of autopsy \_\_\_\_\_

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)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature James D. Smith (M. D. or other) \_\_\_\_\_  
 Address 218 Prof. Bldg Date signed 6/17/48  
R.C. No.

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

3/18 Professional  
11-6

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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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address A. C. W.

**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.**