

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:
5331 Highland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Months
(Specify whether years, months or days) 6 months

3: (a) PRINT FULL NAME JOHN CASEY

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 None

6: (b) Name of husband or wife _____ 6: (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 19 1864
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Daniel Casey 4

13. Birthplace Ireland (State or foreign country)

14. Maiden name Margaret Buckley

15. Birthplace Ireland (State or foreign country)

16: (a) Informant Sister Emile

(b) Address 5331 Highland

17: (a) Removal (b) Date thereof 10/28/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, Mo.

18: (a) Signature of funeral director Quicks Tabin Co.

(b) Address 20 West Linwood

19: (a) 10-28-48 (b) Geraldine 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. 5331 Highland
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 28th day Oct
year 1948 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from Oct 21st, 1948, to Oct 28, 1948
that I last saw him alive on Oct 28, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

CARDIAC DECOMPENSATION 1 YEAR

Due to CHRONIC MYOCARDITIS 0 YRS

Due to GENERALIZED ARTERIO-SCLEROSIS 15 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

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? 0

John T. Skinner (Specify type of place)

While at work? _____ Means of injury _____

23. Signature John T. Skinner (M. D. or other) M.D.

Address 1402 Bryant Bldg Date signed 10/28/48

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

MAR 11 1949

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 Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Kansas City, 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.