

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

30180

State File No.

3766

FILED SEP 22 1951

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Jackson		a. STATE Missouri		b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (in this place) 50 years		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3419 Jefferson				d. STREET ADDRESS (If rural, give location) 3419 Jefferson			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) MRS. MARY		b. (Middle)		c. (Last) CASEY		(Month) (Day) (Year) Aug. 27, 1951	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Apr 14 1878	
9. AGE (in years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? ---		13a. FATHER'S NAME Patrick McCavick		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE John M. Casey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME <i>John P. Casey</i>		ADDRESS 3419 Jefferson	
18. CAUSE OF DEATH				MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		8/25/51	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
				DUE TO (b) Arterio-sclerosis - Hypertension			
				DUE TO (c)			
				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		3314	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/18, 1948</u> to <u>8/27, 1951</u> , that I last saw the deceased alive on <u>8/27, 1951</u> , and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <i>Edward C. Carrier</i> (Degree or title)				23b. ADDRESS 242 Olive St. St. Louis		23c. DATE SIGNED 8/31/51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Aug 30 1951		24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City Missouri	
DATE REC'D BY LOCAL REG. 9-4-51		REGISTRAR'S SIGNATURE <i>Geraldine Holmes</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Dwight G. Robin Co</i>		ADDRESS 20 W. Linwood	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Forrest D. Coldenow

Licensed Embalmer No.

4714

P. O. Address

H. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.