Health, & Welfare Public Service

S. 300
. 1-56

FILED MAY 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13030
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1789

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1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City. Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) De Lora Rest Home 622 Benton Length of stay in 1b 49 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City, M Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 6132 Walnut St. Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First JAMES Middle ARTHUR Last CASEY

4. DATE OF DEATH Month Day Year April 14, 1957

5. SEX Male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 20, 1881
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Michael J. Casey
14. MOTHER'S MAIDEN NAME Catherine Cosgrove

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address Mrs. Anna Happer-6132 Walnut, K.C.Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Left Cerebral hemahage — 5 days
DUE TO (c) Hypertension Moderate 33/X — years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO X 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1940, to 4-14-57 and last saw ~~her~~ him alive on 4-14-57
Death occurred at 6 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John T. Skinner MD
22b. ADDRESS 1102 Grand K.C.Mo
22c. DATE SIGNED 4-16-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/17/57
23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS Quirk & Tobin-20 W. Linwood, K.C.Mo.
25. DATE RECD. BY LOCAL REG. 4-17-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John T. Skinner

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

KP
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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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed William M. Turne

Licensed Embalmer No. 46

20 W. Linwo

P. O. Address.....

Kansas City, M

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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