

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038696

FILED VS NOV 1 0 1959

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 180

ENDED

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Twpnship		Length of stay in 1b 12 8 14	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 940 West 32nd St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First John Middle Justin Last Casey			4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-4-86	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Missouri		12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME Thomas J. Casey		13b. MOTHER'S MAIDEN NAME Elizabeth C. Johnston		14. NAME OF HUSBAND OR WIFE Kathryn 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 State Hospital #3 Address Nevada, Missouri		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			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) Atherosclerosis			Years
	DUE TO (c) Diabetes Mellitis			Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) -----	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		-----	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 **February 20, 1947** to **Nov. 4, 1959** and last saw him alive on **Nov. 4, 1959**
Death occurred at **11:40 a.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>George Esker, M.D.</i> (Degree or title)	22b. ADDRESS State Hospital #3 Nevada, Missouri	22c. DATE SIGNED 11-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 6, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION (City, town, or county) (State) Nevada, Missouri
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24. FUNERAL DIRECTOR Richard L. Shorten. Nevada, Mo.	25. DATE RECD. BY LOCAL REG. Nov 6-1959	26. REGISTRAR'S SIGNATURE <i>Anna E. Jorgy</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

Signature of Student Embalmer

Signed *David C. McLeod*

Licensed Embalmer No. 4853

P. O. Address Florida, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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