

IRI DIVISION OF HEALTH AND STANDARD CERTIFICATE OF DEATH

OF PUBLIC HEALTH AND WELFARE

6304-60-045962
STATE FILE NUMBER

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

FILED VS JAN 11 1967

NEED

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, give TOWNSHIP only) Kansas City		Length of stay in 1b 26 yrs.		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 Trinity Lutheran Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 112 So. Van Brunt			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First BEN		Middle RALPH		Last CASEY		Month Day Year Dec. 13, 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-16-96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist			10b. KIND OF BUSINESS OR INDUSTRY Pharmacy	11. BIRTHPLACE (City and state or country) McCune, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME George Casey			13b. MOTHER'S MAIDEN NAME Barbara Fox		14. NAME OF HUSBAND OR WIFE Anna Casey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW# 1			16. SOCIAL SECURITY NO. 487-07-7192		17. INFORMANT Address Patricia Casey-- 112 So. Van Brunt		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Chronic myocardial infarction						9 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis						3 1/2 yrs.	
DUE TO (c) Obesity - Gout						3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NO						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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" 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 a.m. p.m. NO	Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Nov. 1, 1960 to 12-13-60 and last saw her alive on 12-13-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M. B. Casbolt				22b. ADDRESS 4000 Ballinger		22c. DATE SIGNED 12-14-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-16-60	23c. NAME OF CEMETERY OR CREMATORY Frontenac Cemetery		23d. LOCATION (City, town, or county) (State) Frontenac, Kansas		
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar-1800 E. Linwood				25. DATE RECD. BY LOCAL REG. 12-15-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer	

DOCUMENT

BY AFFIDAVIT OF M. B. Casbolt MEDICAL CERTIFICATION

D. M. B. Co.
4000 Bel

2nd - 2:30 - 6

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gerald A. Burger

Licensed Embalmer No. 426

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.