RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1961

-60-045964

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1062 Registrar's No. 6359

DED

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 70 Yrs

c. CITY OR TOWN Kansas City
Inside Limits: Yes XX No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp
Inside Limits: Yes X No ☐

d. STREET ADDRESS (If outside, give location) 900 Winchester
Reside on Farm: Yes ☐ No XX

3. NAME OF DECEASED (Type or print): First WILLIAM Middle E Last CASEY

4. DATE OF DEATH: Month December Day 16 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married X Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 11/11/79

9. AGE (last birthday): 81

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): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (City and state or country): Creston Iowa

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John Casey

13b. MOTHER'S MAIDEN NAME: Paulina Gist

14. NAME OF HUSBAND OR WIFE: Mary Alice Casey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNK.

17. INFORMANT: Mary A Casey
Address: 900 Winchester K C Mo

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)	Acute Auricular Fibrillation	12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Myocardial Decompensation	3 hrs
DUE TO (c)	Arteriosclerotic Heart Disease	4 yrs

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.
☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 Dec 14-60, to Dec 16 60 and last saw her/him alive on Dec 16-60

Death occurred at 2:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John M Powers M.D.

22b. ADDRESS: 3304 Linwood

22c. DATE SIGNED: 12/17/60

BY AFFIDAVIT OF John M. Powers MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 12/19/60

23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Cemetery

23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR ADDRESS: Shell Funeral Home Kansas City Mo

25. DATE RECD. BY LOCAL REG.: 12-19-60

26. REGISTRAR'S SIGNATURE: H-L-Dwyer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4954

P. O. Address K.C. Mo.

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