

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(c) Name of hospital or institution: Little Sisters of the Poor
(d) Length of stay: In hospital or institution about 20 yrs.
In this community 38 yrs.

3. (a) PRINT FULL NAME Simon Carey
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Carey (deceased) 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 6 1855
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 8 27 hr. min.

9. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business no

12. Name Carey
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Kane
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Kane
(b) Address 812 Ewing St., K. C. Mo.

17. (a) Burial (b) Date thereof 3/6/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn, Indep. Mo.

18. (a) Signature of funeral director John P. Sheil
(b) Address Kansas City, Mo.

19. (a) 3/5/42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 812 Ewing St.
(e) If foreign born, how long in U. S. A.? 38 yrs. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 3 day 3 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 28 1942 to March 3 1942 that I last saw him alive on March 2 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial pneumonia 5 days
Due to Generalized arteriosclerosis

Due to Senile dementia
Other conditions 109

Major findings: Of operations no
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of Injury UMD
23. Signature John P. Sheil (M. D. or other) UMD
Address 1402 B... Date signed 3-4-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration
Physician
Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed John P. Leed

Licensed Embalmer No. 3625

P. O. Address N. C. - 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 this body is not embalmed, fact should be so stated above.