

No. 2
-12-45
5-17-39
I X47020

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41599

FILED DEC 26 1947/49

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5203

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City - Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
The Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-29-47 to
12-10-47 (Specify whether
In this community since birth
years, months or days)

3. (a) PRINT FULL NAME KENNETH Walter Caley

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 27 1933
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>14</u>	<u>6</u>	<u>13</u>	hr. min.

9. Birthplace Kansas City Mo. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation School boy

11. Industry or business _____

12. Name Walter Roosevelt Caley

13. Birthplace Kansas City Mo. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Francis Virginia Rimb

15. Birthplace Kansas City Mo. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Walter Caley

(b) Address 3231 Park Ave., K.C., Mo.

17. (a) Burial (b) Date thereof 12-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (e) Signature of funeral director Melody-McGilley-Eylar

(b) Address Kansas City, Missouri

19. (a) 12-11-47 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3231 Park - K.C. Mo.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 1947 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from
3-28, 1947, to 12-10, 1947
that I last saw h. 100 alive on 12-10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Ulcerative Colitis

Due to same

Other conditions (Include pregnancy within 3 months of death) 1206

Major findings: Of operations _____

Of autopsy Hypertensive + Ulcerative Colitis; Emaciated

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? _____ (City or town) (County) (State)

(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 _____

23. Signature H.M. Suller (M. D. or other) 0

Address 1624 Prof Bld. Date signed 12-10-47

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.