

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9868**
Registrar's No. **1302**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **two days**
In this community **Uniontown** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ben Calia** **450**

8. (b) If veteran, name war **no** 8. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **maid**

6. (b) Name of husband or wife **Minnie Calia** 6. (c) Age of husband or wife if alive **22** years

7. Birth date of deceased **Feb 8 1892**
(Month) (Day) (Year)

8. AGE: Years **48** Months **1** Days **15** If less than one day hr. min.

9. Birthplace **Italy**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business **Tax Business**

12. Name **John Calia**
13. Birthplace **Italy**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Larossa**
15. Birthplace **Italy**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Minnie Calia**

(b) Address **599 Forest**

17. (a) **Burial** (b) Date thereof **3/24/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. St. Marys Cem**

18. (a) Signature of funeral director **G. Schubert**

(b) Address **901 Oak 5th St**

19. (a) **Mch 25, 1940** (b) **M. M. Grower**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
599 Forest
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24th**
year **1940** hour **7** minute **23 A.M.**

21. I hereby certify that I attended the deceased from **3-22-40**, 19, to **3-24-40**, 19;
that I last saw **him** alive on **3-24-40**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic vascular nephritis with uremia
Hypertensive heart Disease

Due to **131**

Other conditions **Generalized atherosclerosis**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy **See above**
Underline the cause to which death should be charged statistically.

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 **P. J. De Maria M.D.** (M. D. or other)
Address **Supt. K. C. Gen. Hosp., K. C. Mo.** Date signed _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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. 2060

P. O. Address 1807 E 29th

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, above space should be left blank.