

AUG 14 1940

Registration District No. _____

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 1 day
(Specify whether _____)
In this community unknown
years, months or days

3. (a) PRINT FULL NAME TONY PANZIERO 576

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex M 6. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 62 Months + Days + If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business
MOTHER FATHER { 12. Name Salvatore Panziero
13. Birthplace Italy
14. Maiden name Unknown
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Salvatore Panziero

(b) Address 2526 Rochester

17. (a) Burial (b) Date thereof 7/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director G. Spibets

(b) Address 901 E. 5th St
19. (a) July 15, 1940 (b) M. H. Brown
(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")
(d) Street No. Rochester & Grand Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13th
year 1940 hour 8 minute 40 A. M.

21. I hereby certify that I attended the deceased from July 12th, 1940, to July 13th, 1940,
that I last saw him alive on July 13th, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to grip

Due to _____
Other conditions Terminal bronchopneumonia
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: See above

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)
Means of injury _____

23. Signature Dwight R. Shovel (M. D. or other)
Address Supt. K. C. Gen. Hosp., K. C. Mo. Date signed _____

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

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.....

Roy E. Snow

Licensed Embalmer No. *2560*

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.