

No. 2
1-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5940
712

State File No. _____
Registrar's No. _____

MAILED MAR 14 1943 99
Registration District No. _____

Primary Registration District No. 1002

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

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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
In this community 25 yrs
years, months or days)

3. (a) PRINT FULL NAME: S Mary Terino Capito

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nick Capito 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Nov 15 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 3 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace McAlister (I.T.) Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Carmon Terino

13. Birthplace Italy 5
(City, town, or county) (State or foreign country)

14. Maiden name Andersson

15. Birthplace Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Nick Capito

(b) Address 500 Montgall

17. (a) Burial (b) Date thereof 2/19/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt St Mary's Cem

18. (a) Signature of funeral director T. Carralls (Schiffman)

(b) Address 901 E 5th

19. (a) 2/18/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 500 Montgall
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16
year 1941 hour 5³⁰ pm minute _____ M.

21. I hereby certify that I attended the deceased from 2-15-41
_____, 19____, to 2-16, 1941;
that I last saw her ex alive on 2-14, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Due to Post-operative

Due to Shock

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

Major findings: Perianal cyst
Of operations Multiple adhesions
Of autopsy Multiple adhesions causing hemorrhage

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 0

23. Signature W. W. Allyn Green (M. D. or other MD)
Address Kansas City, Mo. Date signed 2-18-41

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

W. W. Greene
Professional Embalmer

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 _____

Ray E Snow

Licensed Embalmer No. 2560

P. O. Address 1807 E 29

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.