

FILED MAR 14 1941
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. 10
(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 30 yrs
years, months or days)

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. 536 Troost Avenue
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3. (a) PRINT FULL NAME DOMINIC MISCIASI (Misciasi)

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

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

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

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

8. AGE: Years 65 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 _____

12. Name Anthony Misciasi

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

14. Maiden name Maria Abbota

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

16. (a) Informant Joe De Luna Frank De Luna

(b) Address 536 Troost

17. (a) Burial (b) Date thereof 2/22/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cavlyr Cemetery

18. (a) Signature of funeral director Adelbeta Funeral Home

(b) Address 901 E 5th St. S. Canella

19. (a) 2/21/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20th
year 1941 hour 8 minute 10 A. M. P. M.

21. I hereby certify that I attended the deceased from 2-19-41 19____ to 2-20-41 19____;
that I last saw him alive on 2-20-41 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Corciac decompensation

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy None

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? 3/11 (Specify type of place) _____

(e) Means of injury 3/11 _____

23. Signature Amey R. Thorne (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital, K. 6th

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

89608

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.