

FILED MAY 16 1949

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13423

State File No. 1404

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town a Kansas  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2416 E. 6th St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 33 Years  
years, months or days)

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. 2416 E. 6th St.  
(If rural, give location)  
(e) Citizen of foreign country? 33 Years (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Catherine Guarino

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

4. Sex Female race White 5. Color or divorced Married  
6. (b) Name of husband or wife Mr. Paul Guarino 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased July 21 1893  
(Month) (Day) (Year)

8. AGE: Years 48 Months 8 Days 17 If less than one day  
hr. min.

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

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER { 12. Name Anthony Caracci  
13. Birthplace Italy  
(City, town, or county) (State or foreign country)  
14. Maiden name Joe Ann Medoline  
15. Birthplace Italy  
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Guarino  
(b) Address 2416 E 6th St.

17. (a) Burial (b) Date thereof April 12 1949  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. St. Marys

18. (a) Signature of funeral director Passantino Bro's.  
(b) Address K. C. Mo.

19. (a) Apr 9, 1949 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29  
year 1949 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from August 7, 1940  
April 1940 to April 19 1949  
that I last saw her alive on 4/7/49  
and that death occurred on the date and hour stated above.

Immediate cause of death  
uremia  
Hypertension

Due to Cardio Vasculer renal

Due to 131

Other conditions (Includes pregnancy within 3 months of death)

Major findings: non.

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
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 9

23. Signature R. W. Stoff (M. D. or other)  
Address 1022 Argyle Bldg Date signed 4/9/49

Duration  
1 yr  
18 wonds  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 *Paul G. Rowe*

Licensed Embalmer No. *2348*

P. O. Address *K. C. Mo.*

**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.**