

FILED MAY 16 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13460
State File No. _____
1441
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 100

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:
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 2 days
In this community 32 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 9
(d) Street No. 337 South Indiana
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country — 0

3. (a) PRINT FULL NAME

Louis Pollaro

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Santa Pollaro
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Oct 5 1878
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 6
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business none

MOTHER FATHER { 12. Name Vincent Pollaro
13. Birthplace Italy (City, town, or country) (State or foreign country) 5
14. Maiden name Pasqua De Angelo
15. Birthplace Italy (City, town, or country) (State or foreign country) 5

16. (a) Informant Vincent Pollaro

(b) Address 5100 Brooklyn

17. (a) Burial (b) Date thereof April 14-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cthly

18. (a) Signature of funeral director Santerio Bros

(b) Address 15 Gmo

19. (a) Apr. 10, 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th
year 1941 hour 3 minute 50 A. M.

21. I hereby certify that I attended the deceased from 4-9-41 19... to 4-11-41 19...
that I last saw him alive on 4-11-41 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to ASL
Due to ASC
Other conditions (Include pregnancy within 9 months of death)

Major findings: Of operations _____
Of autopsy None

Duration _____
PHYSICIAN _____
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? 0

(Specify type of place) _____
While at work? _____ Means of injury _____
23. Signature May R. Hill (M. D. or other) _____
Address Med. Bldg. Gen. Hospital Date signed _____

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.....

Park B Rowe

Licensed Embalmer No. *2347*

P. O. Address..... *11 C MD*

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.