

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

FILED FEB 6 1945
Registration District No. 149

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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1139 Pacific 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 30 years / _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Kansas City MO 40
(If outside city or town limits, write "RURAL")

(d) Street No. 1139 Pacific 8
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nick Fiorello

3. (b) If veteran, name war _____ No. none

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1945 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1-6
1945, to 1/13-1945

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 6 1870
(Month) (Day) (Year)

that I last saw my alive on 1/12
and that death occurred on the date and hour stated above.

Immediate cause of death 60x leucis

8. AGE: Years 75-74 Months 1 Days 7
If less than one day _____ hr. _____ min.

Due to Acute lobar (Pneumonia (A))

Due to _____

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

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

10. Usual occupation none

Major findings: Of operations 108

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Do not know

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

14. Maiden name Do not know

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

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? _____

16. (a) Informant Mrs Joe Desjefano

(b) Address 1139 Pacific

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Mt St. Marys

23. Signature R. J. Alardino (M. D. or other) _____
Address 721 Realts Bldg Date signed 1-15/45

18. (a) Signature of funeral director Paroncio Bros

(b) Address Kansas City MO

19. (a) 1-15-45 (Date received local registrar)

(b) T. E. Brown (RB) (Registrar's signature)

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.....

Francis Walton

Licensed Embalmer No..... *2744*

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.