

No. 2
M-2-43
5-17-39
X35967

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20443**
Registrar's No. **2920**

FILED JUL 15 1946

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: **Osteopathic Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 weeks**
(Specify whether)

In this community **4 yrs**
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. **670 Tracy**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **PHILLIP BECORARO**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **490-16-1562**

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **June** day **30** year **1946** hour **9:30** minute **P.** M.

4. Sex **Male** 5. Color of race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Genevieve Beoraro**

6. (c) Age of husband or wife if alive **25** years

7. Birth date of deceased **April 26 - 1885**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 15** 19**46** to **June 30** 19**46** that I last saw him alive on **June 30** 19**46** and that death occurred on the date and hour stated above.

8. AGE: Years **61** Months **2** Days **4** hr _____ min. **5**

Immediate cause of death **Bronchopneumonia**

Due to **Chronic myocardial Failure**

Due to **Mitral insufficiency**

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

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

Major findings: **92 B**

10. Usual occupation **Baker**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business **Toppa Bakery**

12. Name **Lucretia Becoraro**

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

14. Maiden name **Maria Becoraro**

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

16. (a) Informant **Genevieve Becoraro**

(b) Address **670 Tracy**

17. (a) **Burial** (b) Date thereof **7-13-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Wladyslaw**

18. (a) Signature of funeral director **Edna E. Taylor**

(b) Address **KCM**

19. (a) **7-2-46** (b) **M. D. or other**
(Date received local registrar) (Registrar's signature)

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 **g**

23. Signature **D. A. Hoskins** (M. D. or other) **DO**

Address **2105 Independence Ave** Date signed **July 1-46**

KCMo.

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.