No. 2
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 6 1946

Registration District No. 749

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33430

State File No.

Primary Registration District No. 1002

Registrar's No. 4495

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: 3 days (Specify whether years, months or days)
In this community: unknown

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.: 512 Woodland
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Rose Ancona
3. (b) If veteran, name war: no
3. (c) Social Security No.: Do not know
4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: unknown
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March 19 1851 (Month) (Day) (Year)
8. AGE: Years 65 Months 7 Days 5 If less than one day hr. min.
9. Birthplace: Italy (City, town, or county) (State or foreign country)
10. Usual occupation: none
11. Industry or business:
MOTHER FATHER
12. Name: Venant Conte
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)
16. (a) Informant: Jack Ancona
(b) Address: 400 Wabash
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 29-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt St Mary's
18. (a) Signature of funeral director: Panarino Bros
(b) Address: K.C. Mo
19. (a) 10-26-46 (Date received local registrar) (b) Geraldine Holman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25th year 1946 hour 10 minute 50 P.M.
21. I hereby certify that I attended the deceased from 10-22-46, 19..., to 10-25-46, 19...; that I last saw her alive on 10-25-46, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized arteriosclerosis; Senility — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death): 97
Major findings: Of operations:
Of autopsy: None

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: Wm W. Hart M.D. (M.D. or other)
Address: Asst. Dir. K.C. Gen. Hospital Date signed: 10-26-46

(Licensed Embalmer's Statement on Reverse Side)

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.