

FILED OCT 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30206

4117

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) Kansas City | |
| c. LENGTH OF STAY (In this place) 2 years | | d. STREET ADDRESS (If rural, give location) 2705 E. 35 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1 | | | |

| | | | | |
|--|------------|-------------|--------------------------------|--------------------------------------|
| 3. NAME OF DECEASED (Type or Print) Mary | a. (First) | b. (Middle) | c. (Last) DiGiovanna | 4. DATE OF DEATH 9 25 1949 |
|--|------------|-------------|--------------------------------|--------------------------------------|

| | | | | | | | | |
|-------------------------|----------------------------------|--|---------------------------------------|--|---------------------------|-------------------------|-------------------------|------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 11-23-1902 | 9. AGE (In years last birthday) 46 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HR. Hours | IF UNDER 1 HR. Min. |
|-------------------------|----------------------------------|--|---------------------------------------|--|---------------------------|-------------------------|-------------------------|------------------------|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Italy | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|---|--|

| | | |
|---|---|--|
| 13a. FATHER'S NAME Frank Moritabano | 13b. MOTHER'S MAIDEN NAME Almazo Monacalo | 14. NAME OF HUSBAND OR WIFE Anthony DiGiovanna |
|---|---|--|

| | | | |
|---|--|--|------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) None | 16. SOCIAL SECURITY NO. Donot know | 17. INFORMANT'S SIGNATURE OR NAME Anthony DiGiovanna | ADDRESS KCMO |
|---|--|--|------------------------|

| | | | | |
|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute military tuberculosis | | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ | | |
| | | DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|---|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **Sept. 13, 1949**, to **Sept. 25, 1949**, that I last saw the deceased alive on **Sept. 25, 1949**, and that death occurred at **4:45 P.M.**, from the causes and on the date stated above.

| | | | |
|--------------------------------------|-------------------|--|------------------------------------|
| 23a. SIGNATURE Wm. W. Hart | (Degree or title) | 23b. ADDRESS Med. Dir. Gen'l Hosp. | 23c. DATE SIGNED 9-26-49 |
|--------------------------------------|-------------------|--|------------------------------------|

| | | | |
|--|--------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Sept 28-49 | 24c. NAME OF CEMETERY OR CREMATORY Mt St Marys | 24d. LOCATION (City, town, or county) (State) Kansas City Mo |
|--|--------------------------------|--|--|

| | | | |
|--|--|--|------------------------|
| DATE REC'D BY LOCAL REG. 9-26-49 | REGISTRAR'S SIGNATURE Seraldine Holmes | 25. FUNERAL DIRECTOR'S SIGNATURE Passerelli Bros | ADDRESS KCMO |
|--|--|--|------------------------|

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

R. M. Mung...

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.