

THE DIVISION OF HEALTH OF MISSOURI
FILED MAR 6 1950 STANDARD CERTIFICATE OF DEATH

4803

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>750</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>30 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City 3/18</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cherokee Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>908 Chestnut</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>MICHAEL</u> b. (Middle) <u>COSTELLO</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>2-15-50</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>9-29-1871</u>			
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Anthony Costello</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. E. Husby</u> ADDRESS <u>908 Chestnut</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Chronic Granular Nephritis of Urinaria</u>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Granular Nephritis of Urinaria</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5-8 yrs</u>	
* 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) <u>Advanced Age, Arteriosclerosis, Carcinoma of Stomach (pyloric)</u>				DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Failure Heart and Gastrointest</u>									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION. <u>Failure Heart and Gastrointest</u>							
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) <u>Kansas City Mo. Jackson</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		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 <u>Jan 30, 1950</u> , to <u>2-15, 1950</u> , that I last saw the deceased alive on <u>2-15, 1950</u> , and that death occurred at <u>2:20 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>A.S. Linville</u> (Degree or title) <u>Dr. A. S. Linville M.D.</u>				23b. ADDRESS <u>6120 Chamberland</u>		23c. DATE SIGNED <u>2-18-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-21-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		24d. LOCATION (City, town, or county) (State) <u>KC Mo</u>			
DATE REC'D BY LOCAL REG. <u>2-18-50</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Detrich</u>		ADDRESS <u>Eastern Kansas</u>			

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

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



Licensed Embalmer No. 4973

P. O. Address RC No

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.