

FILED APR 23 1951

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12449

1404

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1404	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, write RURAL and give township) Pensacola City 3058		a. STATE Mo		b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Pensacola City 3058		c. LENGTH OF STAY (In this place) 2 days		c. CITY (If outside corporate limits, write RURAL and give township) Pensacola City 3058		d. STREET ADDRESS (If rural, give location) 643 Benton Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp.							
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) YETE		b. (Middle) BADA		c. (Last) LUCCO		4. DATE OF DEATH (Month) (Day) (Year) 3-31-51	
5. SEX MO		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 4-22-1893	
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Anthony Badalucco		13b. MOTHER'S MAIDEN NAME Katherine		14. NAME OF HUSBAND OR WIFE Delio Badalucco			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1941-42		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME Delio Badalucco		ADDRESS 643 Benton	
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				INTERVAL BETWEEN ONSET AND DEATH			
II. OTHER SIGNIFICANT CONDITIONS				ANTECEDENT CAUSES			
Conditions contributing to the death but not related to the disease or condition causing death.				Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
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 June 5, 1950, to Mar. 31, 1951, that I last saw the deceased alive on Mar. 31, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.							
23a. SIGNATURE D. R. Black (Degree or title) M.D.				23b. ADDRESS 924 Professional Bldg.		23c. DATE SIGNED 4/2/51	
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE 4-3-51		24c. NAME OF CEMETERY OR CREMATORY Mt St Mary Cem.		24d. LOCATION (City, town, or county) (State) Ke Mo	
DATE REC'D BY LOCAL REG. 4-2-51		REGISTRAR'S SIGNATURE Geraldine Holmes		25. GENERAL DIRECTOR'S SIGNATURE		ADDRESS	
				Geraldine Holmes		Ke, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Donald Black.
Professional Bldg.
-V18481
202214

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Francis J. Macton*

Signed
Student Embalmer

Licensed Embalmer No. *2744*

P. O. Address *KC, 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.