

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8357**
1082

FILED MAR 22 1952
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 MO b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	c. LENGTH OF STAY (In this place) 48 yrs	c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY 10	
d. FULL NAME OF HOSPITAL OR INSTITUTION 727 FOREST		d. STREET ADDRESS (If rural, give location) 727 FOREST 3150	

3. NAME OF DECEASED (Type or Print) a. (First) JOE b. (Middle) (FOUNTA) c. (Last) FONTANAZZA			4. DATE OF DEATH (Month) (Day) (Year) 3 4 1952		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH MAY 1885	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICE MAN (RET)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 5 SICILY-Italy		12. CITIZEN OF WHAT COUNTRY? ITALY	
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13a. FATHER'S NAME GIOVANNI FONTANAZZO		13b. MOTHER'S MAIDEN NAME CARMELA ?		14. NAME OF HUSBAND OR WIFE PEPINA FONTANAZZO			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOHN FONTANAZZO 3204 WINDSOR			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) COXEMIA				INTERVAL BETWEEN ONSET AND DEATH 3-25-51	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) carcinoma of prostate gland				3-25-51	
		DUE TO (c) arteriosclerosis				11	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				11	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **3-25, 1951**, to **3-4, 1952**, that I last saw the deceased alive on **3-19, 1951**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Geraldine Holmes MD		(Degree or title)		23b. ADDRESS 1540 S. W. 10th St. Kansas City, Mo.		23c. DATE SIGNED 3-6-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-7-52		24c. NAME OF CEMETERY OR CREMATORY MT ST MARY'S CEM		24d. LOCATION (City, town, or county) (State) K.C. MO	
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DATE REC'D BY LOCAL REG. 3-7-52		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SEBETO'S K.C. Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Form 1040
Maryland
Baltimore

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.....

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.