

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34947

State File No. _____

4525

FILED NOV 8 1952

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</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>45 YRS.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
		d. STREET ADDRESS (If rural, give location) <u>3200 Norledge</u>	

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3. NAME OF DECEASED (Type or Print) <u>Michaeli DeFeo</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 15 52</u>		
a. (First)	b. (Middle)		c. (Last)		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>9-19-?</u>		9. AGE (In years last birthday) <u>app. 75</u>

IF UNDER 1 YEAR Months Days Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. INS. AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRUDENTIAL INS.</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
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13a. FATHER'S NAME <u>BERNARDI DE FEO</u>		13b. MOTHER'S MAIDEN NAME <u>CAROLINA CALABRESE</u>		14. NAME OF HUSBAND OR WIFE <u>NONE.</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>F. MARAUZINO 6E. 62 TERR. K.C. MO.</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>491X</u>	

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 Sept. 18, 1952, to Oct. 15, 1952, that I last saw the deceased alive on Oct. 15, 1952, and that death occurred at 8:45A m., from the causes and on the date stated above.

23a. SIGNATURE <u>B.I. Burns M.D.</u>		23b. ADDRESS <u>24th & Cherry</u>		23c. DATE SIGNED <u>10-15-52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10-18-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. MO.</u>	
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DATE REC'D BY LOCAL REG. <u>10-17-52</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eylar K.C. MO.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr Thompson

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 *Wm E. Hark*

Signed.....
Student Embalmer

Licensed Embalmer No. *4063*

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.