

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27019**
3375

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) 44 yrs		c. CITY OR TOWN Kansas City		d. Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 309 Ord Ave				f. STREET ADDRESS 309 Ord Ave				g. (If rural, give location) 310 8	
3. NAME OF DECEASED (Type or Print) a. (First) Frank			b. (Middle) ANCONA			c. (Last) ANCONA			
4. DATE OF DEATH (Month) (Day) (Year) JULY 14-54			5. SEX Male			6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Aug 29 1881			9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (City and State or Foreign Country) Italy		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME John Ancona			13b. MOTHER'S MAIDEN NAME Francos Macaluso			
14. NAME OF HUSBAND OR WIFE Maxia Ancona			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO. 510-05-4477			
17. INFORMANT'S SIGNATURE OR NAME Maxia Ancona			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Myocardioses			18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. ADDRESS 12 CMO			19. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Decompensation			20. AUTOPSY? 4 year			
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Nephritis			19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			
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) (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 Jan , 19 53 , to July 14 , 19 54 , that I last saw the deceased alive on July 11 , 19 54 , and that death occurred at _____ m., from the cause and on the date stated above.									
23a. SIGNATURE (Degree or title) John O. Skinner, M.D.			23b. ADDRESS 1402 Bryant Bldg.			23c. DATE SIGNED 7/16/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial			24b. DATE 7-19-54			24c. NAME OF CEMETERY OR CREMATORY Mt St Marys Cemetery			
24d. LOCATION (City, town, or county) (State) Kansas City MO			25. FUNERAL DIRECTOR'S SIGNATURE Geraldine Smith			25. ADDRESS Passantino Bros 12 CMO			
DATE REC'D BY LOCAL REG. 7-16-54			REGISTRAR'S SIGNATURE			25. ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

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 
Signature of Student Embalmer

Signed *Forest Caldwell*

Licensed Embalmer No. *47*

P. O. Address *H. B. G.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.