

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11791**

FILED APR 25 1955
BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1346**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 60 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Luke's Hospital		3. STREET ADDRESS (If rural, give location) 523 Cherry 303 8	
3. NAME OF DECEASED a. (First) Mary		b. (Middle) Bono	
c. (Last) Bono		4. DATE OF DEATH (Month) (Day) (Year) 3 23 55	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED DIVORCED (Specify) 2		8. DATE OF BIRTH OCT 28 1875	
9. AGE (in years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (City and State or Foreign Country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JACK ASTA		13b. MOTHER'S MAIDEN NAME FRANCES PALERMO	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME PETER F. BONO ADDRESS KC Mo	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PREPYLORIC MALIGNANT ULCER ANTECEDENT CAUSES WITH MASSIVE HEMORRHAGE. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) BILATERAL BROSOPNEUMONIA DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1517	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE David M. Gibson (Degree or title) MD (Pathologist)		23b. ADDRESS St Luke's Hospital K.C.Mo.	
23c. DATE SIGNED 3/23/55		24. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 3-26-55		24c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	
24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI		DATE REC'D BY LOCAL REG. 3-26-55	
REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE Wella D. Kozietan ADDRESS K.C.Mo.	

(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.....
Detee B. Lopez

Licensed Embalmer No. 477

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