

Health, Welfare, Public Service
 300
 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Frank Paul Laurenzana

FILED MAR 6 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 5055

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 817

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, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SUNNY REST HOME SOYES			Length of stay in 180		d. STREET ADDRESS 512 CAMPBELL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST VITO TOE TORICE				4. DATE OF DEATH Month Day Year 2-17-1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876	9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR			10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) ITALY 5		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN TORTORICE				14. MOTHER'S MAIDEN NAME MARY MIGLIAZZO			
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. NONE		17. INFORMANT Address JOSEPH TORTORICE 504 GARFIELD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) arteriosclerosis				3 yrs	
		DUE TO (c)				4500	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 2-14-57 to 2-17-57 and last saw her alive on 2-17-57. Death occurred at 545 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Frank Paul Laurenzana M.D. (Degree or title)				22b. ADDRESS 428 S. White Ave		22c. DATE SIGNED 2-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-21-1957	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM		23d. LOCATION (City, town, or county) KANSAS CITY, MO		(State)	
24. FUNERAL DIRECTOR ADDRESS PASSANTINO BROS KC - MO			25. DATE RECD. BY LOCAL REG. 2-20-57		26. REGISTRAR'S SIGNATURE Neva Minchall		

De Lawrence

Died - 2-17-57 5:45 PM

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 *Leonard Passantini*

Licensed Embalmer No. *45*

P. O. Address *KC Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.