

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36076

STATE FILE NUMBER

4495

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

|  |                             |  |   |
|--|-----------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>               |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                             | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research</u> Length of stay in 1b. <u>4 yrs</u>   |                             | d. STREET ADDRESS (If outside, give location) <u>618 Tracy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>        |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>JOSEPHINE PUSATERI</u>  |                             |  | 4. DATE OF DEATH<br>Month Day Year<br><u>9 25 57</u>  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>FEB 8 1894</u>   |
| 9. AGE (In years last birthday) <u>63</u>  |                             | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country) <u>Italy</u>   |
| 12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>  |                             | 13. FATHER'S NAME <u>Unk</u>   |   |
| 14. MOTHER'S MARDEN NAME <u>Unk</u>  |                             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT <u>Frank Pusateri</u> Address <u>618 Tracy</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>   |                             |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                             |  | DUE TO (b) <u>Pulmonary Congestion &amp; Heart Failure</u> <u>24 Hrs.</u>                         |
|  |                             |  | DUE TO (c) <u>Cholecystitis with Cholelithiasis</u> <u>Years.</u>                                 |
| 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?<br>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<br>Hour Month, Day, Year<br>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 <u>20 Sept '57</u> to <u>25 Sept '57</u> and last saw her/him alive on <u>25 Sept '57</u> .<br>Death occurred at <u>10:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                             |  |   |
| 22a. SIGNATURE (In free or title)<br><u>Wallace H. Graham, M.D.</u>  |                             | 22b. ADDRESS<br><u>518 Argyle Bldg.</u>  |   |
| 22c. DATE SIGNED<br><u>27 Sept '57</u>   |                             |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br><u>9-28-57</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenlawn Cem.</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>Hickman Mills Mo.</u>                         |
| 24. FUNERAL DIRECTOR<br><u>Sebbeto Funeral Home N.-C. Mo.</u>  |                             | 25. DATE RECD. BY LOCAL REG.<br><u>9-27-57</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Neva Minshall</u>   |

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
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  
Wallace H. Graham

518  
array  
B.C.G.

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, ~~by~~ ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Forrest D. Goldsnow*.....

Licensed Embalmer No. *4714*

P. O. Address *K.C. Mo*

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