

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026750

FILED VS JUL 26 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3568

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 53 yrs.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Northeast Osteopathic Hosp.		d. STREET ADDRESS (If outside, give location) 1000 Jackson	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MRS. FRANCES BURASCO			4. DATE OF DEATH Month Day Year July 7, 1960		
5. SEX Female	6. COLOR OR RACE Italian	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1885	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) San Biaggio, Italy		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Anthony Morreale		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Joseph Burasco	

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 Mrs. Rose Deeds 1000 Jackson	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 2 years
DUE TO (b) Essential vascular hypertension			7
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Malnutrition			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown	
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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 a.m. p.m.	Month, Day, Year		

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 November 16, 1959	COUNTY July 7, 1959	STATE July 6, 1959
21. I attended the deceased from November 16, 1959 to July 7, 1959 and last saw her July 6, 1959 alive on July 6, 1959 Death occurred at 2:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Frank E. Day D.D.</i>	(Degree or title)	22b. ADDRESS 4314 E. 9th St. K.C. Mo.	22c. DATE SIGNED 7-8-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-9-60	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Melody McGilley-Eylar Funeral Home 1800 E. Linwood Blvd.		25. DATE RECD. BY LOCAL REG. 7-9-60	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. F...
4314 E.

BFI-01

Friday

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dale C. Martin

Licensed Embalmer No. 5106

P. O. Address St. Louis

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.