

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016022

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2446 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		Length of stay in 1b 58 YEARS	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 Menorah Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1845 E. 85th Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Joseph Middle Falcone Last Falcone			4. DATE OF DEATH Month April Day 26 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-27-04	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROKER	10b. KIND OF BUSINESS OR INDUSTRY INSURANCE	11. BIRTHPLACE (City and state or country) Kansas City Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
--	---	--	--

13a. FATHER'S NAME ANGELO FALCONE	13b. MOTHER'S MAIDEN NAME MARIA BUTTAGOLE	14. NAME OF HUSBAND OR WIFE MRS. THERESA FALCONE
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT MRS. THERESA FALCONE Address 1845 E. 85th Street Kansas City Mo.
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hour
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"/> No <input type="checkbox"/> Unknown

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 COUNTY _____ STATE _____

21. I attended the deceased from **1950** to **4/26/63** and last saw him alive on **4/26/63**.
Death occurred at **4:15 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul Moss M.D.	22b. ADDRESS 4706 Broadway	22c. DATE SIGNED 4/26/63
---	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 29 1963	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR D.W. Newcomer's Sons Address 1331 Brush Cr. Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 4-26-63	26. REGISTRAR'S SIGNATURE Paul Moss
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
1
2 **3438**
3
4 **0**
5 **1**
6
7 **0**
8 **0**
9 **4201**
10
11
12 **61-0**
13

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF PAUL MOSS

USE BLACK INK OR TYPEWRITER RIBBON

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 *Paul J. Henry*

Licensed Embalmer No. 1724

P. O. Address *JC 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.

11
100

0 - 0 0

0.19