

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020345

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2708 STATE FILE NUMBER

FILED MAY 29 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
Laurence Johnson  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>59 yrs.</u>	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) <u>Trinity Ruth. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>325 Ord</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JACK</u> Middle <u>TITONE</u> Last			4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1903</u>
9. AGE (last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Transportation Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KC Courier-Flight Co.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City MO USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph Titone</u>	13b. MOTHER'S MAIDEN NAME <u>Rosalie Polo</u>
14. NAME OF HUSBAND OR WIFE <u>Eulalia</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Eulalia Titone</u> Address <u>325 Ord</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>9+ yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA OF BLADDER</u>			
DUE TO (c) <u>  </u>			
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 <u>  </u> Month, Day, Year <u>  </u>			
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>1954</u> to <u>5-7-63</u> and last saw him alive on <u>5-7-63</u> Death occurred at <u>about 10:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Laurence Johnson MD.</u>		22b. ADDRESS <u>1316 Professional Bldg</u>	22c. DATE SIGNED <u>5-9-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-10-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City MO</u>
24. FUNERAL DIRECTOR <u>Luigianino Bros KC MO</u>		25. DATE RECD. BY LOCAL REG. <u>5-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Bong</u>

USE BLACK INK OR TYPEWRITER RIBBON

*C. Johnson*  
*Dr. Johnson* - U1 23707  
Prof. Body

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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 *L. C. Parentino*

Licensed Embalmer No. 4554

P.O. Address KC 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.