

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027630

4136

STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. _____

FILED AUG 9 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City North</u>		Length of stay in 1b <u>20 Yrs.</u>	c. CITY OR TOWN <u>Kansas City North</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>7 Englewood Road</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7 Englewood Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>M.</u> Last <u>Fiore</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1963</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-2-1910</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	
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 <u>At The Home</u>		11. BIRTHPLACE (City and state or country) <u>Morris Mines, Penn.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Pasqual Cathlina</u>		13b. MOTHER'S MAIDEN NAME <u>Teresa Gagliardo</u>		
14. NAME OF HUSBAND OR WIFE <u>Mr. James E. Fiore</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. _____			17. INFORMANT Address <u>Mr. James E. Fiore-7 Englewood Rd. K.C., Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>						
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.						
DUE TO (b) <u>Coronary Occlusion</u>						
DUE TO (c) <u>Coronary Thrombosis</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 checked="" 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 <u>6-22-1963</u> to <u>7-6-1963</u> and last saw her/him alive on <u>7-6-1963</u> Death occurred at <u>8:30</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Frank Campbell M.D.</u>			22b. ADDRESS <u>4712 A Vivion Rd. K.C. 19, Mo.</u>		22c. DATE SIGNED <u>7/22/1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 23, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elgin Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Mystic, Iowa</u>		
24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer's Sons-North Kansas City, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-23-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

Frank Campbell MEDICAL CERTIFICATION

VS 300 Rev. 4/59
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23/11

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 John V. Henrich
Licensed Embalmer No. 4848

P. O. Address S. C. 17 1/2

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.