

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-036401**  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5044

**FILED SEP 27 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>45 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Braton Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3322 Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JOSEPH RERES</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Sept. 12, 1963</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-8-1877</u>	<b>9. AGE (last birthday)</b> <u>85</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired). <u>Fruit and Vegetable Vendor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Mezzoiso, Italy</u>		<b>12. CITIZEN OF WHAT COUNTRY</b>	
<b>13a. FATHER'S NAME</b> <u>Steven Reres</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Dorothy Burrieschi</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mrs. Fannie Reres</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Mrs. Fannie Reres - 3322 Charlotte St.</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Adenocarcinoma of Prostate</u>		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		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <u>1/29/52</u> to <u>9/12/63</u> and last saw <sup>her</sup> him alive on <u>9/12/63</u> Death occurred at <u>8 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					

<b>22a. SIGNATURE</b> (Degree or title) <u>C. G. Letch MD</u>		<b>22b. ADDRESS</b> <u>808 So 15 Blumington Ave</u>		<b>22c. DATE SIGNED</b> <u>9/12/63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>9-16-1963</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's Cemetery</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Missouri</u>					

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Melody-McGilley-Eyler Funeral Home</u> <u>Linwood &amp; WOODLAND</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-15-63</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Bessie Smith</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

VS:300 Rev. 4/59	
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USE BLACK INK OR TYPEWRITER RIBBON

C. G. Letch MEDICAL CERTIFICATION

Mr C. B. Litch  
808 S. 15 Blue Springs  
C A 8-5327

ACO  
AC 9-3200

**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

*James W. Waver*

Licensed Embalmer No. 4650

P. O. Address K. C., 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.