

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039808

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5475 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 4 1963

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) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>64 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) HOSPITAL OR INSTITUTION <u>Baptist Mem. Hospital</u>		Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>720 Lydia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>TERESA A. CACIOPPO</u>			4. DATE OF DEATH: Month Day Year <u>10-8-1963</u>	
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5. SEX <u>Fe</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1899</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Anthony Regalia</u>	13b. MOTHER'S MAIDEN NAME <u>Mamie Pecuraro</u>	14. NAME OF HUSBAND OR WIFE
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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>Mary Cacioppo 720 Lydia</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
IMMEDIATE CAUSE (a)	<u>Pulmonary Edema</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Dissecting aortic aneurysm</u>	
DUE TO (b)	<u>Generalized Atherosclerosis</u>	
DUE TO (c)		
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.)
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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
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21. I attended the deceased from <u>March 1954</u> to <u>10-8-63</u> and last saw her alive on <u>10-8-63</u> Death occurred at <u>10:43</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles S. Cooper M.D.</u>	22b. ADDRESS <u>618 Prop. Bldg K.C. Mo.</u>	22c. DATE SIGNED <u>10-10-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-11-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>
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24. FUNERAL DIRECTOR <u>Ravantino Brown K.C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-10-63</u>	26. REGISTRAR'S SIGNATURE <u>Beasie Smith</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF CHARLES S. COOPER, MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Cooper
Professional

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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 *A. G. Passantino*

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.