

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039819

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5354 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

FILED OCT 21 1963

1. PLACE OF DEATH 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>60 yrs</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (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>527 Gillis</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Antonina</u> Middle <u>Carriddi</u> Last <u>Carriddi</u>			4. DATE OF DEATH Month <u>October</u> Day <u>1st</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>12-18-87</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
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		11. BIRTHPLACE (City and state or country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Michael Angelo Costa</u>			13b. MOTHER'S MAIDEN NAME <u>Francesca Anzelmo</u>			14. NAME OF HUSBAND OR WIFE <u>Carlo</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>Mrs Henry Russo 519 S. Jackson</u>		

19. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease with Complete Heart Block</u> DUE TO (b) <u>4206</u> DUE TO (c) <u>444 Essential Hypertension + Arterio-sclerosis 4503</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Nephrosclerosis with Anemia 446</u>		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 <u> </u> a.m. <u> </u> p.m. 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 July 1963 to Oct 1, 1963 and last saw her alive on Oct 1, 1963
 Death occurred at 3251 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jack W. Wolf M.D.</u>		22b. ADDRESS <u>409 E. 63 St. Kansas City, Mo.</u>		22c. DATE SIGNED <u>Oct 2, 1963</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-4-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>SEBBETO FUNERAL HOME K. C. MO.</u>			25. DATE RECD. BY LOCAL REG. <u>10-3-63</u>		26. REGISTRAR'S SIGNATURE <u>Beaie Smith</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED
 1 VS 300 Rev. 4/59
 2 23038
 3
 4 1
 5 1
 6
 7 2
 8 3
 9 4/2x
 10
 11
 12 h-l-D
 13

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Jack W. Wolf

USE BLACK INK OR TYPEWRITER RIBBON

11-20-19-1018
2112

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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 Farrest D. Colburn

Licensed Embalmer No. 4714

P. O. Address R. 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.