

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039893

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5412

DO NOT WRITE ON THIS STUB

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Rev. 4/59

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AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
Kansas City Length of stay in 1b 67 yrs

c. FULL NAME OF (If NOT in hospital, give location)
Research Hospital Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson

c. CITY OR TOWN Kansas City Inside Limits Yes No

d. STREET ADDRESS (If outside, give location)
3707 E 9 Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
SALVATORE TUDIE FALCONE 10-4-1963

5. SEX Male 6. COLOR OR RACE Wh. 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 5-4-1896 9. AGE (last birthday) 67 IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (City and state or country) Kansas City Mo 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Jack Falcone 13b. MOTHER'S MAIDEN NAME Virginia Siroguas 14. NAME OF HUSBAND OR WIFE Rose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. — 17. INFORMANT Rose Falcone Address 3707 E 9

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute pulmonary edema; right heart failure due to pulmonary fibrosis PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Oct. 3, 1952 to Oct. 4, 1963 and last saw him alive on Oct. 4, 1963
Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Ralph Perry M.D. 22b. ADDRESS Suite 300 Research Medical Office Bldg; 6400 Prospect 22c. DATE SIGNED 10-7-63

23a. BURIAL, CREMATION, or DISPOSAL (Specify) Burial 23b. DATE 10-7-1963 23c. NAME OF CEMETERY OR CREMATORY Mt Olive 23d. LOCATION (City, town or county) (State) Kansas City Mo.

24. FUNERAL DIRECTOR Assantius Bros KC Mo ADDRESS — 25. DATE RECD. BY LOCAL REG. 10-7-63 26. REGISTRAR'S SIGNATURE Bessie Smith

USE BLACK INK OR TYPEWRITER RIBBON

Pr King
6400 Airport
3rd Flr.

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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 Al Santoro

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.