REC'D JUN 8 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17541
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson — Registration District No. 399

(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 1943

(c) City Kansas City — (d) Street No. General Hospital St. (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 18 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos.? ds.

2. PRINT FULL NAME 620 Francesca POWERS

(a) Residence, No. 1014 Broadway St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jack Powers

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sep. 30, 1891

7. AGE: 47 YEARS — MONTHS: 7 — DAYS: 5 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy.

FATHER
13. NAME: John Landolfa.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy.

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Vincent Powers (Son) 5020 Wyoming.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Calvary DATE: 5-8, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Gates Funeral Home K. C. Kans

20. FILED: May 8, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 5-5-39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., 19...

I last saw h... alive on ....., 19... Death is said to have occurred on the date stated above, at 11:20 P.M.

Deputy Coroner

The principal cause of death and related causes of importance were as follows:

	Date of onset
Auto traumatism	
Rupture of the diaphragm	
Rupture of the spleen	

Other contributory causes of importance: Hemothorax + hemoperitoneum

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 5-4-39

Where did injury occur? K. C. Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury: Pedestrian struck by auto

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Victor W. Walter, M. D.

(Address) Gen Hosp; K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

X14028

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 .....,

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.