

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30997**
3560
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community Life
years, months or days)

8. (a) PRINT FULL NAME STEVE LA CULIA
8. (b) If veteran, name war no **3. (c) Social Security** No. no

4. Sex male **5. Color or race** white **6. (a) Single, widowed, married,** divorced Single
6. (b) Name of husband or wife — **6. (c) Age of husband or wife if** —
7. Birth date of deceased Nov. 28 - 1923
(Month) (Day) (Year)

8. AGE: Years 16 Months 9 Days 13 If less than one day
hr. min.

9. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business —
12. Name James V. LaCulia **7**
13. Birthplace Alessandro Italy
(City, town, or county) (State or foreign country)
14. Maiden name Angelia Triangolo
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. H. R. Nelson
(b) Address Independence, Mo.

17. (a) Cremation **(b) Date thereof** Sep 12-40
(Burial, cremation, or inhumation) (Month) (Day) (Year)
(c) Place: Elemental Cemetery

18. (a) Signature of funeral director W. & Mitchell
(b) Address Independence, Mo.
19. (a) Sept. 11, 1940 **(b)** M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
0 **(d) Street No.** Brumm Farm, Indep. Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. 11 **day**
year 1940 hour 12 minute 30 **A.** **M.**
21. I hereby certify that I attended the deceased from Sept. 9th 1940 **to** Sept. 11 1940 **19**
that I last saw him live on Sept. 11th, 1940 **19**
and that death occurred on the date and hour stated above.

Immediate cause of death Acute anterior poliomyelitis
Due to _____
Due to 16
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Dr. H. C. Gen Hosp. (M. D. or other)
Address K.C. Gen. Hosp., K.C., Mo.
(Specify type of place) (Address of injury)

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 me

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

Signed Henry J Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep, 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 this body is not embalmed, above space should be left blank.