

FILED JUN 27 1942

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2332

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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether)

In this community 47 Years
years, months or days

3. (a) PRINT FULL NAME FRANK CASANOVA

3. (b) If veteran, name war World War

3. (c) Social Security No. none

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 alive _____ years

7. Birth date of deceased Dec. 23, 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>5</u>	<u>22</u>	_____ hr. _____ min.

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

10. Usual occupation Cafe Owner

11. Industry or business Casanova Cafe

MOTHER FATHER { 12. Name Louis Casanova

13. Birthplace Italy
(City, town, or county) (State or foreign country)

14. Maiden name Anna Marie Garofalo

15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Claude Bellinger

(b) Address 3939 Wayne

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 6-17-42
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery
Phos. . Quirk

18. (a) Signature of funeral director 4316 Troost

(b) Address _____

19. (a) 6-16-42
(Date received local registrar)

(b) M. M. Crowe
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3939 Wayne
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1942 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from _____, 1940 to June 15, 1942; that I last saw him alive on June 15, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Rupture Cerebral Artery
Duration 3 da

Due to syphilitic degeneration
5 yrs

Due to _____

Other conditions 20y
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Rupture Cerebral Arteries

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? _____

While at work? _____

(Specify type of place) _____

(e) Means of injury 0

23. Signature E. A. Burkhardt (M. D. or other) MD

Address 3346 Summit K. C. Mo Date signed 6/15/42

561

July 2 - 1922

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 Thomas J. Hunt

Licensed Embalmer No. 3775

P. O. Address N.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 this body is not embalmed, fact should be so stated above.