

FILED AUG 17 1942

Registration District No. **1799**

Primary Registration District No. **1002**

Registrar's No. **2990**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **K.C.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St. Joseph's**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 hrs.** (Specify whether
In this community **15 hrs.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **K.C.**
(If outside city or town limits, write "RURAL")
(d) Street No. **537 Frost** (If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Infant Kathlene Scola**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **SD**

6. (b) Name of husband or wife **0** 6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **8** (Month) **7** (Day) **42** (Year)

8. AGE: Years Months Days If less than one day **15** hr. min.

9. Birthplace **K.C.** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation **inf.**

11. Industry or business

12. Name **Joe Scola**

13. Birthplace **K.C.** (City, town, or county) **Mo** (State or foreign country)

14. Maiden name **Mary Teresa Catalana**

15. Birthplace **K.C.** (City, town, or county) **Mo** (State or foreign country)

16. (a) Informant **Joe Scola**

(b) Address **537 Frost**

17. (a) **Burial** (b) Date thereof **8/18/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. St. Marys Cem.**

18. (a) Signature of funeral director **A. Sebby's**

(b) Address **901 E. 5th**

19. (a) **8-8-42** (b) **M. M. Crown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **7** year **1942** hour **7** minute **12 P.** M.

21. I hereby certify that I attended the deceased from **7-7-** 19**42**, to **7-7-** 19**42** that I last saw h. **alive** on **7-7-** 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death **Atelectasis** 19**42**

Due to **Pneumonia**

Due to **6 1/2 wks.**

Other conditions **0**
(Include pregnancy within 3 months of death)

Major findings: **Impaired hearing**
Of operations **both eyes**
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?

While at work? (Specify type of place) (e) Means of injury **0**

23. Signature **A. Sebby's** (M. D. or other **MD**)

Address **103 Grand Ave.** Date signed **8-8**

361

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

48
3
8

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.....

Ray E. Snow

Licensed Embalmer No. *2560*

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 this body is not embalmed, fact should be so stated above.