

S. No. 2
M-5-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23831**

LED AUG 6 1943/49
Registration District No. _____

Primary Registration District No. **1602**

Registrar's No. **3060**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City - Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette
 (c) City or town Lexington
(If outside city or town limits, write "RURAL")
 (d) Street No. R.R. 1
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME GERALD Wayne FIORA
 3. (b) If veteran, name war. No
 3. (c) Social Security No. No

4. Sex M 5. Color or Race W
 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. 3 1935
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 Years 7 Months 9 Days
 hr. min.

9. Birthplace Lexington Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None Child

11. Industry or business _____

12. Name Edward Fiora
 13. Birthplace Lexington Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Chesalberti
 15. Birthplace Novenger Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Fiora
 (b) Address Lexington Missouri

17. (a) Removal (b) Date thereof 7-12-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lexington, Missouri

18. (a) Signature of funeral director Mrs. C.L. Forster
 (b) Address Kansas City Missouri

19. (a) 7-12-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12th
 year 1943 hour 10 minute 50 A.M.
 21. I hereby certify that I attended the deceased from July 7, 1943, to July 12, 1943;
 that I last saw him alive on July 12, 1943;
 and that death occurred on the date and hour stated above.

Immediate cause of death Post Mortem
1. Bronchopneumonia
2. Tuberculosis of lung (cheated)
3. Pleural adhesions
4. Passive Congestion of the viscera
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: Clinical Diagnosis
 Of operations _____
 Of autopsy Examination

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?
(Specify type of place)

While at work _____ (e) Means of injury _____
 23. Signature John H. Washburn M.D.
 Address Miray Childrens Hospital
(City, D. or other) signed 7-13

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 *Theron A. Redman*.....

Licensed Embalmer No. *2737*.....

P. O. Address *F. L. me*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.
Registrar's No. 3060

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution: Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME Gerald Wayne Fiara
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County.....
(c) City or town..... Lexington
(If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: month July day 12
year..... hour..... minute..... M.
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....
Post Mortem
1. Broncho pneumonia
Due to 2. Tuberculosis of lung (healed)
3. Alveolar adhesions
Due to 4. Massive congestion of viscera

Other conditions..... (Include pregnancy within 3 months of death)
Major findings: Chemical diagnosis
Of operations: Tetanus
Placenta actual cause
Healed
Puncture wound on left finger

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Exact date not known
(c) Where did injury occur? Lexington Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature John H. Gaskins M.D. (M.D. or other)
Address..... Date signed.....

SUPPLEMENTAL 1952 71

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

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

S-23831