

FILED JAN 5 1944/49  
Registration District No. 19AA/49

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 St Joseph Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days)

In this community 26 years  
(Specify whether years, months or days)

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. 532 Halmer  
(If rural, give location)

(e) Citizen of foreign country? No (Yes of No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Margarete Luero

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18  
year 1943 hour 3 minute 45 A M.

4. Sex fe 5. Color or race wh

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Frank

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Feb. 28 - 1917  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-16 1943 to 12-18 1943  
that I last saw her alive on 12-17 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 26 Months 9 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Heart failure - pulmonary edema. Toxic effect of pyri.

Due to bronchial pneumonia

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

Due to Obesity

Other conditions Primary - post partum - 30 lbs. Toxic in  
(Include pregnancy within 3 months of death)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Gal Barone

13. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

14. Maiden name Gertrude Victoria

15. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Refused

16. (a) Informant Gal Barone

(b) Address 532 Halmer

17. (a) burial (b) Date thereof 12-22-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt St Marys

18. (a) Signature of funeral director P. E. Brown

(b) Address City

19. (a) 12-21-43 P. E. Brown  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

23. Signature Abraham J. O'Neil (M. D. or other) MD

Address 4711 Central St Date signed 12-19

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**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, fact should be so stated above.**