

**FILED AUG 9 1944**

Registration District No. 177

Primary Registration District No. 1002

Registrar's No. 3077

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 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day, 9 hrs, 25 mins.  
(Specify whether)

In this community 40 yrs  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City **3**  
(If outside city or town limits, write "RURAL")

(d) Street No. 1035 E. 4  
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No) **17**

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Pasquale Centomani

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color W 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Rose 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 6 1875  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 22  
year 1944 hour 11 minute 55 P.M.

21. I hereby certify that I attended the deceased from July 21, 1944, to July 22, 1944  
that I last saw him alive on July 22, 1944  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>69</u>	<u>4</u>	<u>16</u>	_____ hr _____ min.

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

10. Usual occupation Retired

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

**MOTHER FATHER**

12. Name Domenick Centomani

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

14. Maiden name Angela Pasquale

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

16. (a) Informant Nocco Centomani

(b) Address 553 Cherry

17. (a) Burial (b) Date thereof 7/26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Edna St. Mary's

(b) Address \_\_\_\_\_

19. (a) 7-26-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

Immediate cause of death  
**MALNUTRITION; DEHYDRATION**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy None

**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) (a) Means of injury

23. Signature W. E. Upsher (M. D. or other) **MD**  
Address Med. Dir. Gen'l Hosp. Date signed 7-24-44

**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

*Dean B. Loggins*

Licensed Embalmer No. *4973*

P. O. Address *KE 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.**