V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23662

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3080

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 3 mos. 1 day (Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State MO (b) County Jackson 3
(c) City or town Kansas City MO 8
(If outside city or town limits, write "RURAL")
(d) Street No. 2511 Elma
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Epifane DeMarco Epifane
3. (b) If veteran, name war — no
3. (c) Social Security No. unk.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mrs Josephine DeMarco
6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased Jan 6 (Month) 1885 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
59	6	19	hr. min.

9. Birthplace Italy (City, town, or county) 5 (State or foreign country)
10. Usual occupation Labor
11. Industry or business
FATHER
12. Name Joe DeMarco
13. Birthplace Italy (City, town, or county) 5 (State or foreign country)
MOTHER
14. Maiden name Giuseppa Scarzia
15. Birthplace Italy (City, town, or county) 5 (State or foreign country)
16. (a) Informant Mrs Josephine DeMarco
(b) Address 2511 Elma
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt St. Marys
18. (a) Signature of funeral director Pasantino Bros
(b) Address Kansas City MO
19. (a) 7-26-44 (Date received local registrar) (b) H. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1944 hour 12 minute 35 P. M.
21. I hereby certify that I attended the deceased from April 24, 1944, to July 25, 1944;
that I last saw him alive on July 25, 1944;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bilateral broncho-pneumonia: Carcinoma of lip with metastases	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 45a	
Major findings: Of operations	
Of autopsy See above	

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 0
23. Signature A. E. Upsher (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 7-26-44

861 (Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Primary Registration District No..... Registrar's No.....

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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)
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

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

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME.....

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.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)
} FATHER

14. Maiden name.....
15. Birthplace.....
(City, town, or county) (State or foreign country)
} MOTHER

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

17. (a) Burial, cremation, or removal.....
(Burial, cremation, or removal)
(b) Place.....
(c) Address.....

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

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

20. DATE OF DEATH: Month.....day.....
year.....hour.....minute.....A. M.

21. I hereby certify that I attended the deceased from.....19.....to.....19.....; that I last saw it alive on.....19.....; and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Due to.....

Due to.....

Other conditions.....
(Contributing, but not related to immediate cause given above)

MEDICAL CERTIFICATION

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be attributed.

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)

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.....
working under my personal supervision.

Signed, Paul E. Rowe Registered Apprentice No.....

Licensed Embalmer No. 2347

P. O. Address 1 Como

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.

(Licensed Embalmer's Statement on Reverse Side)

V. S. No. 2
1001A — 3-43
R. 5-17-39
1 X33327

WHITE PAPER — USE BLACK INK — WRITE A LEGIBLE RECORD