

FILED OCT 24 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33347

State File No.

4055

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)
In this community 46 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 6434 Baltimore Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Mrs Teresa NIGRO

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Frank Nigro

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased February
(Month)

7th 1898
(Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>46</u>	<u>8</u>	<u>1</u>	hr. min.

9. Birthplace Kansas City M
(City, town, or county)

Missouri
(State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Samuel A. Nigro

13. Birthplace Unknown
(City, town, or county)

Italy
(State or foreign country)

14. Maiden name Anna Ruffulo

15. Birthplace Unknown
(City, town, or county)

Italy
(State or foreign country)

16. (a) Informant Frank Nigro

(b) Address 6434 Baltimore Street

17. (a) Burial (b) Date thereof 10-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody McGilley

(b) Address Kansas City Missouri

19. (a) 10-9-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8th
year 1944 hour 9:15 minute P. M.

21. I hereby certify that I attended the deceased from Pathologist
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Cardiac hypertrophy
Due to Arteriosclerosis
Arteriosclerotic nephritis
Due to Pulmonary edema
and congestion

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy as above

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 _____

23. Signature Loaine Sherwood (M. D. or other) _____
Address Pathologist Date signed _____

St. Joseph Hospital, K. C., Mo.

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

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 *Russell A France*

Licensed Embalmer No. *4255*

P. O. Address *K.C. 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.