

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 14 1945

Registration District No. 177

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:  
General Hospt.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution one day  
(Specify whether)  
 In this community 20 Years.  
years, months or days

3. (a) PRINT FULL NAME ANTONIA JACINTO  
antonia jacinto  
 3. (b) If veteran, name war XX  
 3. (c) Social Security No. none

4. Sex Fe. 1 | 5. Color or race W.  
 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife unknown  
 6. (c) Age of husband or wife if alive            years

7. Birth date of deceased June 13, 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>57</u>	<u>14</u>	<u>          </u> hr. <u>          </u> min.

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

10. Usual occupation House wife

11. Industry or business           

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

16. (a) Informant Apolinar Jacinto  
 (b) Address 2404 Mercier

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45  
(Month) (Day) (Year)  
 (c) Place: burial or cremation St. Marys Cem.

18. (a), Signature of funeral director H. Tigerman & Sons  
 (b) Address K. U. Mo.

19. (a) 1-29-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

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. 2404 Mercier  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country           

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 27  
 year 1945 hour 3:15 minute P M.

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

Immediate cause of death Coronary sclerosis

Due to Pulmonary edema

Due to           

Other conditions             
(Include pregnancy within 3 months of death)

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

Major findings:  
 Of operations History of Fracture  
 Of autopsy no

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 J. M. Waller 3 (M. D. or other) Crown  
 Address 1924 Jefferson Ave Date signed 1-28-45

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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 J. S. Walton

Licensed Embalmer No. 2744

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.**