

FILED FEB 6 1945

State File No. _____

Registration District No. 144

Primary Registration District No. 1012

Registrar's No. 301

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K6
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Research Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 wk
In this community 50 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town K6
(If outside city or town limits, write "RURAL")
(d) Street No. 3639 1/2 Prospect
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH LOMBARDO

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced. W

6. (b) Name of husband or wife Madina 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Dec 24 1888
(Month) (Day) (Year)

8. AGE: 56 Years 0 Months 24 23 Days If less than one day hr. min.

9. Birthplace New Orleans La.
(City, town, or county) (State or foreign country)

10. Usual occupation Restaurant Operator

11. Industry or business _____

12. Name Joseph Lombardo

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

14. Maiden name Antonina Lala

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

16. (a) Informant Mrs. Madina Lombardo

(b) Address 3639 1/2 Prospect

17. (a) Burial (b) Date thereof 1/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation balmy home

18. (a) Signature of funeral director Sebbeta's
(b) Address 901 E 5th

19. (a) 1-19-45 (b) J. B. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17th
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from January 7, 1945 to January 17, 1945
that I last saw him alive on January 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage from duodenal ulcer.

Due to _____

Due to _____

Other conditions: 11 78-1
(Include pregnancy within 3 months of death)

Major findings: Not operated.
Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature J. B. Brown (If other) _____

Address 1832 Prof. Bldg. Date signed 1-19-45

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

133
Westinghouse
Perryville

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.....

Ray E. Snow
Licensed Embalmer No. 25-60

P. O. Address *K E M*

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.