V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5350

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 726

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: Polyclinic Hospital D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community 47 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas 44
(If outside city or town limits, write "RURAL")
(d) Street No. 523 Olive St 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country O

3. (a) PRINT FULL NAME Alfonzo Terranello
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rose Terranello
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Dec 19 1877 (Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 22 If less than one day 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 Joseph Terranello
13. Birthplace Italy (City, town, or county) 5 (State or foreign country)
MOTHER
14. Maiden name Magadlena
15. Birthplace Italy (City, town, or county) 5 (State or foreign country)
16. (a) Informant Rose Terranello
(b) Address 523 Olive St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt St Marys
18. (a) Signature of funeral director Passantino Bros.
(b) Address K. C. Mo
19. (a) 2-13-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11
year 1945 hour 7 minute 25 A. M.
21. I hereby certify that I attended the deceased from February 8th 1945, to Feb 11th 1945;
that I last saw him alive on Feb 11th 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema
Due to Mitral Insufficiency
Chronic myocarditis
Due to Coronary Sclerosis
Chronic Interstitial Nephritis
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 131 a
Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Anthony Jeunica (M. D. or other)
Address 2624 Independence Blvd Date signed 2-12-45

(Licensed Embalmer's Statement on Reverse Side)

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 Francis Walter

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.