

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 23 1945

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 1565

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 5 days
(Specify whether years, months or days)

In this community since 1922

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1104 E. Missouri 8
(If rural, give location)

(e) Citizen of foreign country? yes 1 (Yes or No)
If yes, name country Italy

3. (a) PRINT FULL NAME Carl Calcara

3. (b) If veteran, name war no

3. (c) Social Security No. 496-09-7428

4. Sex M 0 5. Color or race w

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

6. (b) Name of husband or wife Ladie

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: Oct 6 1899/1896
(Month) (Day) (Year)

8. AGE: Years 55 58 Months 6 Days 0 If less than one day hr. min.

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

10. Usual occupation Labourer

11. Industry or business

12. Name Jasper Calcara

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

14. Maiden name Vita Ruzza

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

16. (a) Informant Jasper Calcara

(b) Address 914 E 7th Ave

17. (a) Burial (b) Date thereof 4/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem

(a) Signature of funeral director Sebbets

(b) Address 901 E 5th

19. (a) 4-7-45 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 1, 1945 to April 6, 1945
that I last saw him alive on April 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart disease

Due to

Due to

Other conditions (Include pregnancy within 5 months of death) 93 d

Major findings:
Of operations

Of autopsy None

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 Clark W Seely MD
(M. D. or other)

3. Signature Clark W Seely MD Address Med. Dir. Gen'l Hosp Date signed 4-6-45

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

80308

