

Form No. 1
M-5-43
Rev. 5-17-39
I X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26314**
3502
Registrar's No.

FILED
Registration District No. **149**

Primary Registration District No. **1002**

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 Hospital 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community **since 1910**
years, months or days)

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. **1103 Bales 4**
(If rural, give location)
(e) Citizen of foreign country? **Yes 0** (Yes or No)
If yes, name country **Italy**

3. (a) PRINT FULL NAME **Vita Alfano**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **F /** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **M /**
6. (b) Name of husband or wife **John**
6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **Mar 19 1897**
(Month) (Day) (Year)

8. AGE: **48** Years **5 0** Months **0** Days
If less than one day hr. min.

9. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Joseph Monteleone**

13. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

14. Maiden name **Antonia Bruno**

15. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Alfano**

(b) Address **1103 Bales**

17. (a) **Burial** (b) Date thereof **8/22/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Marys Bern**

18. (a) Signature of funeral director **Sebbeto's**

(b) Address **901 E 5th**

19. (a) **8-21-45** (b) **Genevieve Holmes**
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **19**
year **1945** hour **5** minute **35 P.** M.
21. I hereby certify that I attended the deceased from **August 9 45** to **August 19 45**
that I last saw h. **er** live on **August 19 45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Glomerular nephritis, chronic**
Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) **130**

Major findings:
Of operations
Of autopsy **see above**
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 (c) Means of injury
23. Signature **Clark W Seely MD** (M.D. or other)
Address **Med. Dir. K.C. General Hospital** Date signed

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.....

Ray C. Snow

Licensed Embalmer No.....

2560

P. O. Address.....

56 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.