

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29625**
Registrar's No. **3907**

FILED OCT 1 1945
Registration District No. **149**

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 Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether)

In this community 20 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson #8

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

(d) Street No. 1307 Wabash 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Eugene DiBella

3. (b) If veteran, name war none

3. (c) Social Security No. Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20
year 1945 hour 8 minute 15 P M.

4. Sex male 0 5. Color or race white

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

6. (b) Name of husband or wife Josephine 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 14 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from September 14 1945 to September 20 1945
that I last saw him alive on September 20 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 7 Days 6 If less than one day hr. _____ min. 5

Immediate cause of death hypertensive cardio vascular disease

Duration _____

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

10. Usual occupation Re-tread

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph DiBello 5

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

14. Maiden name Antonina Ferris 5

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

Major findings: 93-2

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Josephine DeBello

(b) Address 1709 Prospect Ave

17. (a) Burial (b) Date thereof Sept 24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt St Marys Center

18. (a) Signature of funeral director Parmentier Bros.

(b) Address 126 W 10th

19. (a) 9-21-45 (b) Steadline Holmes
(Data received local registrar) (Registrar's signature)

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

Address Med. Dir. K.C. General Hospital Date signed _____

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 Walton*

..... Licensed Embalmer No. *2744*

..... P. O. Address *12 (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.