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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

40047

State File No. .....

Registration District No. FILED JAN 9 1946 Primary Registration District No. 1002 Registrar's No. 5288

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: KRESTWOODS CONVALESCENT HOME 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 YEAR (Specify whether
In this community unknown
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. 2900 YORK 8
(If rural, give location)

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

If yes, name country ITALY

3. (a) PRINT FULL NAME MRS. MARY CONGEME

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or ~~wife~~ MR CARLO CONGEME

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased APRIL (Month) 24 (Day) 1887 (Year)

8. AGE: Years 58 | Months 7 | Days 27 | If less than one day ..... hr. ..... min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name JASPER INDELICATO
13. Birthplace ..... (City, town, or county) ITALY 5 (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace ..... (City, town, or county) ITALY 5 (State or foreign country)

16. (a) Informant MRS. JOSEPHINE KATOWITZ

(b) Address 2900 YORK

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC-24-1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ MT. ST. MARY'S CEM.

18. (a) Signature of funeral director D. G. Newcomer Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 12-22-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 21 ST year 1945 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from Mar. ....., 1944, to Dec. 21, 1945 that I last saw h[illegible] alive on Dec. 20, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death auricular fibrillation	2 wks.
Due to Hypertension	Unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

95 W

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 A. J. Spafford (M. D. ~~or other~~)

Address Prof. Bldg. K.C. Mo Date signed 12-22-45

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(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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.