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ev. 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. **13591**
1693
Registrar's No. _____

FILED APR 28 1947

Registration District No. 1749

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: General Hospital No. 1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 1 day 2 hrs.
(If not in hospital or institution, write street number or location)

In this community unknown
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 335 Bellefontaine
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Tony Montalte

3. (b) If veteran, name war World War one

3. (c) Social Security 078-05-1120

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs Kate Montalte

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased April 25 1890
(Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 18 If less than one day 5 hr. min

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

10. Usual occupation Operator

11. Industry or business _____

MOTHER FATHER { 12. Name Mathew Montalte

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

14. Maiden name Marie Lotora

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

16. (a) Informant Mrs Kate Montalte

(b) Address 335 Bellefontaine

17. (a) Burial (b) Date thereof 4/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic N.C. MO

18. (a) Signature of funeral director Passantio Bros

(b) Address Kansas City MO

19. (a) 4-14-47 Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13 year 1947 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from April 12, 1947, to April 13, 1947; that I last saw him alive on April 13, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction

Due to _____

Due to _____

Other conditions 94a
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy None

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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wm W Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp Date signed 4-14-47

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

Dr. King

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.