

FILED AUG 13 1947

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 No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether)

In this community 47 yrs.
years, months or days

3. (a) PRINT FULL NAME Thomas Latino

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

3. (c) Social Security No. None

4. Sex MD 5. Color or race W

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

6. (b) Name of husband or wife Anna Mary

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased July 16 1900
(Month) (Day) (Year)

8. AGE: 47 Years 0 Months 10 Days If less than one day hr. min.

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

10. Usual occupation Fruit Merchant

11. Industry or business

MOTHER FATHER

12. Name Salvatore Latino

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

14. Maiden name Rose Shamira

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

16. (a) Informant Mike Latino

(b) Address 415 G Perry

17. (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem

18. (a) Signature of funeral director Sebbetals

(b) Address

19. (a) 7-27-47 (b) Thalidine Holmes
(Date received local registrar) (Registrar's signature)

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. 1225 Independence
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1947 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from July 22 47 to July 26 47
that I last saw him alive on July 26 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Auricular fibrillation

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 95a

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

23. Signature Wm W Hart (M7D 26 47)
Address Med. Dir. Gen'l Hosp. Date signed

Handwritten notes:
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NOV 27 1948

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 E. Snow
Licensed Embalmer No. 2560
P. O. Address 156 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.