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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8707

Registrar's No. 1046

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

(d) Length of stay: In hospital or institution 16 hours  
(Specify whether years, months or days)

In this community 6 months

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. 411 Olive  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas J. Gialde

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased August 25, 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

6 10 hr. min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

12. Name Thomas Gialde

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

14. Maiden name Angeline Cicero

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

16. (a) Informant Thomas Gialde

(b) Address 411 Olive

17. (a) burial (b) Date thereof 3-8-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 2117 Independence Ave.

19. (a) 3-7-48 (b) Theraldine Holman  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5  
year 1948 hour 11 minute 10 P.M.

21. I hereby certify that I attended the deceased from March 4, 1948 to March 5, 1948;  
that I last saw him alive on March 5, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death acute laryngo tracheo bronchitis Duration 16 hrs.

Due to laryngo tracheo broncho obstruction

Due to cerebral anoxemia

Other conditions 106a  
(Include pregnancy within 3 months of death)

Major findings: bronchoscopy & tracheotomy  
Of operations findings above

Of autopsy \_\_\_\_\_

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 Theraldine Holman (M. D. or other) \_\_\_\_\_  
Address 251 Plaza Home Bldg Date signed \_\_\_\_\_

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name THOMAS GIARDE

13. Birthplace KANSAS CITY, MO  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name ANGELINE CIOERO

15. Birthplace KANSAS CITY, MO  
(City, town, or county) (State or foreign country)

16. (a) Informant THOMAS GIARDE

(b) Address 411 OLIVE ST.

17. (a) BURIAL (b) Date thereof 3/8/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director PASSANTINO BROS

(b) Address 2117 INDEP. AVE

19. (a) 3-7-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Branches &  
Of operations Resectomy findings above

Of autopsy \_\_\_\_\_

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 Geraldine Holmes (M. D. or other) \_\_\_\_\_  
Address 251 Plaza Time Bldg Date signed 3/5/48

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.

S-8707 - 1948

Signed *F. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *NC, 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.