

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26254**
3158
Registrar's No. _____

Registration District No. **149**

Primary Registration District No. **1002**

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
(Specify whether
In this community **41 yrs**
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. **908 Independence**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Vito Dolce**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Mar 15 1873**
(Month) (Day) (Year)

8. AGE: Years **75** Months **4** Days **16** If less than one day hr. min.

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Vincenzo Dolce**

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

14. Maiden name **Gracia Savona**

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

16. (a) Informant **Mariana Dolce**

(b) Address **908 Indep ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-4-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Marys Em.**

18. (a) Signature of funeral director **St. Marys Em.**
(b) Address **120 No**

19. (a) **8-3-48** (Date received local registrar) (b) **Geraldine Holmes** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **1**
year **1948** hour **10** minute **A.** M.

21. I hereby certify that I attended the deceased from **July 29** 19**48** to **Aug. 1** 19**48**
that I last saw him alive on **Aug. 1** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident**
Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **830**

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? _____

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

23. Signature **Wm W. White** (M. D. or other) **8-2-48**
Address **Med. Dir. Gen'l Hosp.** Date signed _____

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

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 *John B. Rozetown*

Licensed Embalmer No. 4273

P. O. Address K C 760

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.