

No. 300
-10-47
-17-39
I 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33132

FILED NOV 4 1948

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4111

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 1 day 1 hr.
(Specify whether years, months or days)

In this community 35 years
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Dominica Tortorici

3. (b) If veteran name war no

3. (c) Social Security No. Do not know

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Caralamo Tortorici

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased 1885
(Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Seimund D. Giovanni

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

14. Maiden name Margaret

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

16. (a) Informant Caralamo Tortorici

(b) Address 537 Forest Ave

17. (a) Burial (b) Date thereof: Oct 12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director Pasquino Bros

(b) Address 16 E 2nd

19. (a) 10-9-48 (b) Geraldine 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. 537 Forest
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9
year 1948 hour 3 minute 15 A. M.

21. I hereby certify that I attended the deceased from Oct. 8, 1948, to Oct. 9, 1948,
that I last saw her alive on Oct. 9, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Cerebrovascular accident

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 83A
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: W. W. Hart (Specify type of place) _____
(c) Means of injury _____

23. Signature W. W. Hart (M.D. or other) _____

Address Med. Dir. Gen'l Hosp. Date signed 10-9-48

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

MOTHER FATHER

Dr. R. L. ...

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. LCW

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.