

FILED NOV 16 1948 42  
Registration District No. **42**

Primary Registration District No. **1000**

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town St. Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital # 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 month - 22 days  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Jackson  
 (c) City or town Kansas City Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2700 East 6th Street  
 (If rural, give location)  
 (e) Citizen of foreign country? ? (Yes or No)  
 If yes, name country Born in Italy

**3. (a) PRINT FULL NAME** August Columbo

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

**4. Sex** Male **5. Color of hair** 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** April 4 1876  
(Month) (Day) (Year)

**8. AGE:** Years 72 Months 7 Days 4 If less than one day — hr. — min.

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

**10. Usual occupation** not given

**11. Industry or business** —

**MOTHER FATHER**  
**12. Name** — **13. Birthplace** —  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** —  
**15. Birthplace** —  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** Mr. Lawrence Carr

**(b) Address** 2700 East 6th Street

**17. (a) Removal** — **(b) Date thereof** 11-8-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Kansas City, Mo.

**18. (a) Signature of funeral director** Heator Bowman  
**(b) Address** St. Joseph, Mo.

**19. (a) 11-12-48** **(b) K. G. Jenkins**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month 11 day 8  
year 1948 hour 9 minute 10 M.

**21. I hereby certify that I attended the deceased from** 9-16 1948 to 11-8 1948  
that I last saw him alive on 11-8 1948  
and that death occurred on the date and hour stated above

Immediate cause of death Hypostatic pneumonia  
Duration 8 days

Due to Arteriosclerosis  
Due to —

Other conditions (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.  
 Major findings: Of operations 97  
Of autopsy —

**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 0

**23. Signature** Irish Thomas MD (M. D. or other)  
**Address** State Hospital # 2 **Date signed** 11-8-48

NOV 15 1957

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.....

*Danny O. Becker*....., Registered Apprentice No. *287*  
working under my personal supervision.

Signed..... *William Spelling*.....

Licensed Embalmer No. *4535*

P. O. Address..... *314 S. 10th St. Jc.*

**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.