

S. No. 300
M-10-47
Rev. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39454
Registrar's No. 1403

FILED JAN 3 1948
Registration District No. 42

Primary Registration District No. 5134

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Rural Washington Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Memorial Hy-way R. #6.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution not
(Specify whether
In this community 1 month
years, months or days)

3. (a) PRINT FULL NAME Josephine Golondono
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race Italian
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Dan Golondono
6. (c) Age of husband or wife if alive years

7. Birth date of deceased February 16 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 10 13
hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Fred Golondono

(b) Address R. #6 St. Joseph, Mo.

17. (a) Removal (b) Date thereof Dec. 29, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director Halter Meierhoffer

(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 12-30-48 (b) G. G. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Cook 999
(c) City or town Chicago
(If outside city or town limits, write "RURAL") 11
(d) Street No. 1001 Marshfield
(If rural, give location) 6
(e) Citizen of foreign country? Yes (Yes or No) 20
If yes, name country Italy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29th
year 1948 hour 7 minute 35 A.M.

21. I hereby certify that I attended the deceased from Oct 15,
1948 to Dec 29 1948
that I last saw her alive on Dec 28 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poisoning Duration 24 hours

Due to Chronic Interstitial Nephritis 5 years

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 131a

Of operations

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 Benjamin P. ... other O.O.
Address 6207 Katy, St. Joseph, Mo. Date signed 12-29-48

1987 6 1 10A

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 Albert E. Harrington
Licensed Embalmer No. 3258 Missouri
P. O. Address St. Joseph, 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.