

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **749**

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

In this community 43 yrs.

**3. (a) PRINT FULL NAME** Sadie Calcara

3. (b) If veteran,            name war           

3. (c) Social Security No.           

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife unknown | 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased Jan 27 1899  
(Month) (Day) (Year)

**8. AGE:** Years 49 | Months 11 | Days 3 | 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 Charles Berlin

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

14. Maiden name Rose San Franca

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

16. (a) Informant Vincent Calcara

(b) Address 1104 E 9th Ave

17. (a) Burial (Burial, cremation, or removal) | (b) Date thereof 1/3/49  
(Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Sabbato's

(b) Address City

19. (a) 12-31-48 (Date received local registrar) | (b) Geraldine Holman (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. 1104 E. Missouri Ave.  
(If rural, give location)

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

If yes, name country           

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 30  
year 1948 hour 1 minute 25 A. M.

21. I hereby certify that I attended the deceased from Dec. 28 1948, to Dec. 30 1948, that I last saw her alive on Dec. 30 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Congestive failure

Due to Rheumatic heart disease

Due to           

Other conditions 95%  
(Include pregnancy within 3 months of death)

Major findings: Of operations           

Of autopsy None

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?           

Wm. W. Hart (Specify type of place) | While at work?            (e) Means of injury           

Signature Wm W Hart (M. D. or other) | 12-30-48 Date signed

Address Med. Dir. Gen'l Hosp.

Duration           

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**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 Ray E. Snow  
Licensed Embalmer No. 2560  
P. O. Address KO 7M

**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.**