

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19459

State File No. 2783

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>149</u>  |  | PRIMARY REG. DIST. NO. <u>1002</u>  |  | Registrar's No. <u>2783</u>  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MO</u> b. COUNTY <u>JACKSON</u> |  |  |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY 1</u>  |  | c. LENGTH OF STAY (In this place) <u>40 yrs</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>                                       |  | d. STREET ADDRESS (If rural, give location) <u>510 CAMPBELL</u>        |  |   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>409 N VAN BRUNT</u>  |  |  |  | d. STREET ADDRESS (If rural, give location) <u>510 CAMPBELL</u>   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or Print) <u>CONGETTA CALDARELLO</u>   |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>6 25 49</u> |   |  |  |  |   |  |
| a. (First)   |  | b. (Middle)  |  | c. (Last)   |  |  |  |   |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>   |  | 8. DATE OF BIRTH <u>10/21/1874</u>                                     |  |   |  |
| 9. AGE (In years last birthday) <u>74</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>       |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>ITALY S</u>               |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <u>ITALY S</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>ITALY</u>  |  | 13a. FATHER'S NAME <u>GIUSEPPE MACALUSO</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>MARIA GUCCIONE</u>                        |  |   |  |
| 14. NAME OF HUSBAND OR WIFE <u>(DEC)</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> |  | 16. SOCIAL SECURITY NO. <u>NONE</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MIKE CALDARELLO KC MO</u> |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>  |  |  |  | MEDICAL CERTIFICATION   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3</u> |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>   |  |  |  | PRECEDENT CAUSES DUE TO (b) <u>PULMONARY FIBROSIS</u>   |  |  |  |   |  |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.   |  |  |  | DUE TO (c) <u>BRONCHIAL ASTHMA</u>  |  |  |  |   |  |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION <u>4200</u>   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                           |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>             |  | 21f. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>MAY</u> , 19 <u>49</u> , to <u>JUNE 25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>JUNE 24</u> , 19 <u>49</u> , and that death occurred at <u>3 P.</u> m., from the causes and on the date stated above. |  |  |  |   |  |  |  |   |  |
| 23a. SIGNATURE <u>Edward P. Altomare M.D.</u> (Degree or title)  |  |  |  | 23b. ADDRESS <u>1030 E Pacific K.C. Mo</u>  |  | 23c. DATE SIGNED <u>6/26/49</u>  |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 24b. DATE <u>6/28/49</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>MT ST MARY'S</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO</u>    |  |   |  |
| DATE REC'D BY LOCAL REG. <u>6-28-49</u>  |  | REGISTRAR'S SIGNATURE <u>Heraldine Holmes</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>SEBETO'S</u>  |  | ADDRESS <u>KC MO</u>   |  |   |  |

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Roy E. Snow*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 2560

P. O. Address 156 MW

**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.