

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 12 1949

3121

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (In this place) <u>47 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		11			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>806 Washington</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>			b. (Middle)		c. (Last) <u>BARBERA</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 18, 1949</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug. 2, 1871</u>		9. AGE (In years last birthday) <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME <u>Joseph Barbera</u>			13b. MOTHER'S MAIDEN NAME <u>Beatrice Beverqua</u>			14. NAME OF HUSBAND OR WIFE <u>Anna M. Barbera</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>Mrs. Anna M. Barbera, 806 Washington, KC, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Aortic Stenosis (Calcium)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital deformity of valve (Bicuspid aortic valve)</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pericarditis - acute.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks (?)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>7544</u>						20. AUTOPSY? YES <input checked="" 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)		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>July 10, 1949</u> , to <u>July 18, 1949</u> , that I last saw the deceased alive on <u>July 18, 1949</u> , and that death occurred at <u>10:00 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Edson C. Carrier MD</u> (Degree or title)				23b. ADDRESS <u>242 Olive Medical</u>			23c. DATE SIGNED <u>7/19/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-21-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>7-19-49</u>		REGISTRAR'S SIGNATURE <u>Seraldine Helms</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eyler, Kansas City, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

48
3
8401
40
3
8
9

*H. E. T. Carrigan
Plaza Hotel, Albany,
1 - 6 cases of cases.*

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.