

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42284**
5584

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 35 YRS		d. STREET ADDRESS (If rural, give location) 3200 NORLEDGE 30910	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION K.C. CONVALESCENT HOME			

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH	b. (Middle)	c. (Last) GUARSTELLA	4. DATE OF DEATH (Month) (Day) (Year) 12 20 52
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH SEPT 1883	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? 5	

13a. FATHER'S NAME GEORGE GUARSTELLA	13b. MOTHER'S MAIDEN NAME MARIA SOLA	14. NAME OF HUSBAND OR WIFE MARIA GUARSTELLA
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME MARIA GUARSTELLA	ADDRESS 1018 1/2 E MO AVE
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis		2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arterio sclerosis		Eyes
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4500

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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 **1-10-51**, 19____, to **12-20-52**, 19____, that I last saw the deceased alive on **12-20-52**, 19____, and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Paul Laurence M.D. MD	23b. ADDRESS 428 South White Ave	23c. DATE SIGNED 12-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-22-52	24c. NAME OF CEMETERY OR CREMATORY MT ST MARY'S	24d. LOCATION (City, town, or county) (State) K.C. MO
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DATE REC'D BY LOCAL REG. 12-20-52	REGISTRAR'S SIGNATURE Sheraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE SEBBETO'S	ADDRESS KC MO.
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300
48
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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.

Student

Student Embalmer

Signed

Forrest D. Goldsnow

Licensed Embalmer No. *4714*

P. O. Address

K. C. 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.