

FILED SEP 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30521**
4080

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 MISSOURI b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY	c. LENGTH OF STAY (in this place) 4 YEARS	c. CITY OR TOWN KANSAS CITY	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION RESEARCH HOSPITAL		STREET ADDRESS (If rural, give location) 321 OLIVE STREET 3108	

3. NAME OF DECEASED (Type or Print) a. (First) ELLEN	b. (Middle) J	c. (Last) CILIA	4. DATE OF DEATH (Month) (Day) (Year) AUG 24 1954
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 19-1925
9. AGE (In years last birthday) 29	IF UNDER 1 YEAR Months 3 Days 6	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) MARYSVILLE, KANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRED A. HORN	13b. MOTHER'S MAIDEN NAME ELLEN	14. NAME OF HUSBAND OR WIFE SALVATORE G. CILIA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME ADDRESS SALVATORE G. CILIA, 321 OLIVE ST. K.C. Mo.

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute ileitis and jejunitis	INTERVAL BETWEEN ONSET AND DEATH 2 wks
ANTECEDENT CAUSES	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION 1-18-52	19b. MAJOR FINDINGS OF OPERATION Ulcerative colitis	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 **May 18, 1951**, to **Aug 24, 1954**, that I last saw the deceased alive on **Aug 24, 1954**, and that death occurred at **2:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Martin J. Mueller (Degree or title) M.D.	23b. ADDRESS 936 Angyle Bldg	23c. DATE SIGNED 8-25-54
24a. BURIAL CREMATION REMOVAL (Specify) BURIAL	24b. DATE 8-25-54	24c. NAME OF CEMETERY OR CREMATORY MARYSVILLE CEMETERY
24d. LOCATION (City, town, or county) MARYSVILLE	24e. (State) KANSAS	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dw. Newcomer, Inc. 1331 Branch Creek Bl. Kansas City Mo.
DATE REC'D BY LOCAL REG. 8-25-54	REGISTRAR'S SIGNATURE Heraldine Smith	

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

Colostony

1955
MAY 15

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.....
Signature of Student Embalmer

Signed *Juan T. Deane*

Licensed Embalmer No. *449*

P. O. Address *Hanover*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.