

FILED OCT 7 1954

STANDARD CERTIFICATE OF DEATH

State File No. 30733

4459

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City, Missouri</b>		c. LENGTH OF STAY (in this place) <b>8.0.0.</b>	
c. CITY OR TOWN <b>Kansas City</b>		d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> STREET ADDRESS (If rural, give location) <b>4700 Roanoke Parkway</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Stephen</b> b. (Middle) <b>Gregory</b> c. (Last) <b>MOLLIKA</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>September 19, 1954</b>		
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5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 16, 1893</b>		9. AGE (in years last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>Anthony Mollica</b>		13b. MOTHER'S MAIDEN NAME <b>Angela Fenech</b>		14. NAME OF HUSBAND OR WIFE <b>Fern A. Mollica</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>VA Hospital Official Records - K.C., Mo.</b>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>				<b>5 minutes</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerotic cardio-vascular disease.</b>				<b>years</b>	
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>4201</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)	
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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?	
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22. I hereby certify that I attended the deceased from **D.O.A.**, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, **11/11/1954** and that death occurred at **D.O.A.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dorothy Weybright, M.D.</b>		23b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		23c. DATE SIGNED <b>9-19-54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>SEPT. 20, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>DETROIT MICHIGAN</b>	
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DATE REC'D BY LOCAL REG. <b>9-20-54</b>		REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>D. W. Newsamers</b>		ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Dorothy Weybright

OCT 7

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert Ray*

Licensed Embalmer No. *418*

P. O. Address *K.C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.