FILED JUL 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 0 2 3 3 2 0
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 105

1. PLACE OF DEATH
a. COUNTY: Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Washington Township — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): State Hospital 3 — Length of stay in lb: 3 yrs 12 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City Mo — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 415 Garfield — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle ANN — Last SIMONE

4. DATE OF DEATH: Month June Day 22 Year 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 13, 1934
9. AGE (In years last birthday): 22 — IF UNDER 1 YEAR: Months 11, Days 21 — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Kansas City Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joe Simone
14. MOTHER'S MAIDEN NAME: Anna Mancuso

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Record State Hospital 3 Nevada Mo

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Epileptic Seizure — INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Epilepsy
DUE TO (c): 3533
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis due to Convulsive Disorder (Epilepsy)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 10, 1954, to June 22, 1957 and last saw her/him alive on June 22/57
Death occurred at 2:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul L. Barone, M D, Coroner
22b. ADDRESS: State Hospital 3 Nevada Mo, Nevada, Mo
22c. DATE SIGNED: June 22/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 25 1957
23c. NAME OF CEMETERY OR CREMATORY: Mt. St. Mary's Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City Mo.

24. FUNERAL DIRECTOR ADDRESS: Ferry Funeral Home Nevada, Mo.
25. DATE RECD. BY LOCAL REG.: 6-26-1957
26. REGISTRAR'S SIGNATURE: Anna E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JUL 2 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed L. Douglas Ferry.....

Licensed Embalmer No. 49

P. O. Address Nevada

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