

Health,  
Welfare  
or  
Public  
Service

300  
1-56

All  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Frank Paul Laurenzana

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31852

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4135

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>JACKSON</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HEWELIAN NURS. 35425</b>			Length of stay in lb		d. STREET (If outside, give location) ADDRESS <b>623 EUGLID</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HOWE</b> Middle <b>GUS</b> Last <b>FOGELQUIST</b>				4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>57</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1881</b>		9. AGE (In years last birthday) <b>76</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLASTER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>SWEDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ALBIN FOGELQUIST</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>495-10-5452A</b>		17. INFORMANT <b>82 via Address Law Rafael</b> <b>HILDER STENSSTROM - CALIF</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>4500</b>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>1-1-57</b> to <b>8-30-57</b> and last saw her alive on <b>8-30-57</b> Death occurred at <b>8:25A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>Frank Paul Laurenzana MD</b> (Type or print)				22b. ADDRESS <b>428 S. White Ave</b>				22c. DATE SIGNED <b>8-30-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-6-1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO</b>				
24. FUNERAL DIRECTOR <b>PASSANTINO Bros</b>			ADDRESS <b>KE MO</b>		25. DATE RECD. BY LOCAL REG. <b>9-4-57</b>		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>			

(Licensed Embalmer's Statement on Reverse Side)

*Dr. L. ...*  
Date 8:45 am - 8-30-57

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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 *Leonard G. Passantino*

Licensed Embalmer No. *45*

P. O. Address *KC 7M*

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..