

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35737

STATE FILE NUMBER

4650

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4650

| | | | | | | | |
|---|--------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JACKSON</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH Hosp</u> | | | Length of stay in lb <u>5 1/2 yrs</u> | d. STREET ADDRESS <u>3809 PROSPECT</u> (If foreign, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>COMO</u> Last <u>COMO</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WH.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-11-1905</u> | | 9. AGE (In years last birthday) <u>52</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | 11. BIRTHPLACE (City and state or country) <u>LA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>FRANK GAGLIANO</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY GUARISCO</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNK</u> | | 17. INFORMANT Address <u>VINCENT COMO KCMO</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Essential Hypertension</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> <u>6 wks</u> <u> </u> |
| 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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u> | | | | | | | |
| 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 <u>4/19/57</u> to <u>10/6/57</u> and last saw <u>her</u> alive on <u>10/5/57</u> Death occurred at <u>1:48</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>D. J. Outcliff MD</u> | | | | 22b. ADDRESS <u>1222 Mc Gee</u> | | 22c. DATE SIGNED <u>10/7/57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>10-9-1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>ST MARY'S CEM.</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>PASSANTINO Bros KCMO</u> | | 25. DATE RECD. BY LOCAL REG. <u>10-8-57</u> | | 26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u> | | | |

*Dr. Cutcliff
Nigro Clinic*



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 Lassentino*

Licensed Embalmer No. *45*

P. O. Address *KC Mo*

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