

pt. Health,  
& Welfare  
S. Public  
Health Service

FILED DEC 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47089  
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 202

S. 300  
ev. 1-57

1080  
2

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> <b>3548</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON TWP.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR STATE <b>HOSPITAL #3</b> INSTITUTION <b>NEVADA, MISSOURI</b>		Length of stay in lb <b>19 years</b>	d. STREET ADDRESS (If outside, give location) <b>1913 East 33rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Felicitas</b> First <b>FELICIA</b> Middle <b>INFANTE</b> Last <b>INFANTE</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>14</b> Year <b>1957</b>			
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 22 1900</b>	9. AGE (In years last birthday) <b>57</b> IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>MEXICO 3</b>	12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>
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13a. FATHER'S NAME <b>Fernandez</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>IGNACIO INFANTE</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>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>HOSPITAL RECORDS STATE HOSPITAL #3</b>
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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>CORONARY THROMBOSIS (SUDDEN)</b>		INTERVAL BETWEEN ONSET AND DEATH
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) <b>4201</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <b>2</b>
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20c. TIME OF INJURY Hour <b>7:30</b> Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b> COUNTY <b>Missouri</b> STATE
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21. I attended the deceased from **Oct 1939**, to **Nov 14, 1957** and last saw <sup>her</sup>/<sub>him</sub> alive on **Nov 14, 1957**  
Death occurred at **7:30 a.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul L. Barone</b> (Degree or title) <b>MEDICAL SUPERINTENDENT</b>	22b. ADDRESS <b>STATE HOSPITAL #3 NEVADA, MISSOURI</b>	22c. DATE SIGNED <b>11-14-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>November 16-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Kansas City - Missouri</b>
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24. FUNERAL DIRECTOR <b>Mrs. C.L. Forster Funeral Home, Inc.</b> <b>Kansas City 27 Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-9-1957</b>	26. REGISTRAR'S SIGNATURE <b>Anna J. Ferry</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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MAR 7 1958

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 *John V. Verneker* ..... Licensed Embalmer No. *4848* ..... P. O. Address *J. V. Verneker* .....

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.