

Health,
& Welfare
Public
Service

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010145
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1194

300
1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</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 <u>3522 WALNUT</u> <u>WALNUT NURSING HOME</u>		Length of stay in lb <u>55 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>2001 INDEPENDENCE AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DAVID J.</u> Middle <u>REPETTO S.R.</u> Last <u>REPETTO S.R.</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 6, 1882</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>LITHOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>JOHN REPETTO</u>		13b. MOTHER'S MAIDEN NAME <u>ROSE</u>		14. NAME OF HUSBAND OR WIFE <u>GRACE REPETTO</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>495-05-1479A</u>		17. INFORMANT Address <u>MISSION, KAN</u> <u>MRS. DELLA SLATER-5713 BIRCH</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>Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4:00</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, Generalized.</u>		
	DUE TO (c) <u>General Debility & Heart Disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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>4:00</u> Month, Day, Year <u>NOV 1957</u> a.m. <u>NO</u> p.m. <u>NO</u>					

20d. INJURY OCCURRED WHILE AT <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 <u>518 Argyle Bldg</u>	COUNTY <u>Missouri</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>1 Nov. 1957</u> to <u>2 March 58</u> and last saw him alive on <u>2 March 1958</u> . Death occurred at <u>H. 45 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Wallace H. Graham, M.D.</u>			22b. ADDRESS <u>518 Argyle Bldg</u>		22c. DATE SIGNED <u>4 March 58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MARCH 5, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS-KANSAS CITY, MO</u>			25. DATE RECD. BY LOCAL REG. <u>3-5-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Wallace H. Graham, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. 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.



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 *L. D. Nelson*

Licensed Embalmer No. *4401*.....

P. O. Address *Kansas City, Mo.*.....

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.