

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021976

STATE FILE NUMBER **3011**

FILED JUL 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</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>Menorah Medical Center</b>		Length of stay in 1b <b>1903</b>	d. STREET ADDRESS (If outside, give location) <b>8430 Ward Parkway</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Anthony</b> Middle <b>LoChiano</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-98</b>	9. AGE (In years last birthday) <b>59</b>	10. F UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Rocco LoChiano</b>	13b. MOTHER'S MAIDEN NAME <b>Maria Novarro</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs Leona LoChiano</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>500-20-5120</b>	17. INFORMANT <b>Rocco LoChiano</b> Address <b>LaPorte, Texas</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>Internal Peritoneal Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>0928</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Sub-acute Infectious hepatitis</b>		
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 COUNTY _____ STATE _____
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21. I attended the deceased from <b>Jan 58</b> , to <b>6-13-58</b> and last saw him alive on <b>6-13-58</b> Death occurred at <b>8:20</b> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>M.H. Friedman M.D.</b> (Degree or title)	22b. ADDRESS <b>701 E 63</b>	22c. DATE SIGNED <b>6-16-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-16-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cem</b>	23d. LOCATION (City, town, or country) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Sebbeto Funeral Home</b> ADDRESS <b>K. K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-16-58</b>	26. REGISTRAR'S SIGNATURE <b>Neer Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

M.L. Friedman USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION 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 *Forest D Caldwell*

Licensed Embalmer No. *4714*  
P. O. Address *HC 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.