

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044280
STATE FILE NUMBER
3670

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

1. PLACE OF DEATH
a. COUNTY: Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Mary's Hosp. Length of stay in 1b: 49 yes.

d. STREET ADDRESS (If outside, give location): 2613 Jarboe Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last: Therese Mattione

4. DATE OF DEATH Month Day Year: 11 28 58

5. SEX: Fe. 6. COLOR OR RACE: Wh. 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH: 2-8-1882 9. AGE (In years last birthday): 76 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10b. KIND OF BUSINESS OR INDUSTRY: Home 11. BIRTHPLACE (City and state or country): Neiderbyran, Bavaria 8 12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Frank Rodler 13b. MOTHER'S MAIDEN NAME: Anna Schoenberger 14. NAME OF HUSBAND OR WIFE: Louis Mattione

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No 16. SOCIAL SECURITY NO.: None 17. INFORMANT: Mrs. H.A. Lund Address: Bethel, Kansas.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cerebral Thrombosis + 2nd Bronchitis*
DUE TO (b) *Arterio-sclerosis*
DUE TO (c) *Auricular Fibrillation*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4931

INTERVAL BETWEEN ONSET AND DEATH: 36 days - 5 min

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18):

20c. TIME OF INJURY .Hour .Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 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 1957 to 1/13/58 and last saw her/him alive on 11/28/58. Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): *Edwin C. Cannon, M.D.* 22b. ADDRESS: *242 Plaza Med. Bldg* 22c. DATE SIGNED: *11/29/58*

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 23b. DATE: 12-1-58 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet 23d. LOCATION (City, town, or county) (State): Kansas City Mo.

24. FUNERAL DIRECTOR: Mellody-McGilley-Eylar ADDRESS: 20 W. Linwood 25. DATE RECD. BY LOCAL REG.: 12-1-58 26. REGISTRAR'S SIGNATURE: *Neva Minshall*

(Licensed Embalmer's Statement on Reverse Side)

Edson C. Carrier USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

Dr. Carrier
VA. 1-3434
Physn Med. Bldg.

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 *J. H. Taylor*

Licensed Embalmer No. *2924*

P. O. Address *R. C. ...*

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.