

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013520

STATE FILE NUMBER 1893

FILED MAY 1 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1893

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 625 Forest		Length of stay in lb 50 yrs	d. STREET ADDRESS (If outside, give location) 625 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOSEPH Middle T Last ROMANO			4. DATE OF DEATH Month April Day 14 Year 1959
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 25 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Petroleum-Const.	11. BIRTHPLACE (City and state or country) Salerno Italy
12. CITIZEN OF WHAT COUNTRY? US		13a. FATHER'S NAME Salvatore Romano	13b. MOTHER'S MAIDEN NAME unknown
14. NAME OF HUSBAND OR WIFE Bessie Romano (Deceased)		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 Tony Romano		Address 625 Forest	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60 years Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) acute double pneumonia DUE TO (c) 4-10-59 INTERVAL BETWEEN ONSET AND DEATH 4-10-59			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 _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4-10-59 to 4-14-59 and last saw him alive on 4-14-59 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) A. Saladino, M.D.		22b. ADDRESS 1040 Argyle	
22c. DATE SIGNED 4-15-59		22d. ADDRESS (State)	
23a. BURIAL, CREMATION, REBURIAL (Specify)	23b. DATE 4-17-59	23c. NAME OF CEMETERY OR CREMATORY Mt St Marys	23d. LOCATION (City, town, or county) (State) KC Mo
24. FUNERAL DIRECTOR Chas. B. Rogelina		ADDRESS K.C., Mo.	
25. DATE RECD BY LOCAL REG. 4-15-59		26. REGISTRAR'S SIGNATURE Gene Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

A. Saladino

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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 

Licensed Embalmer No. 4273

P. O. Address C. C. M.

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.