

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017717

STATE FILE NUMBER

FILED MAY 29 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2240

300
1-57

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital		d. STREET ADDRESS (If outside, give location) 347 Tracy	
3. NAME OF DECEASED (Type or print) First Lillian Middle R. Last Gentile		4. DATE OF DEATH Month 5 Day 4 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Give if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) New Orleans La
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Paul DiGiovanni	
13b. MOTHER'S MAIDEN NAME Laura Veltrano		14. NAME OF HUSBAND OR WIFE Carl P. Gentile	
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. -	
17. INFORMANT Carl P. Gentile		Address 347 Tracy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric artery thrombosis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Rheumatic heart disease, Severe with			
DUE TO (c) aortic stenosis and insufficiency			
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.) 411X	
20c. TIME OF INJURY Hour 8:00 Month 4 Day 24 Year 59 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
21. I attended the deceased from 4-24-59 to 5-4-59 and last saw her alive on 5-4-59 Death occurred at 8:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Abraham Galperin		22b. ADDRESS Gen. Hospital	
22c. DATE SIGNED 5-4-59			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	May 6 1959	Mt St Mary's Cemetery	Kansas City MO
25. DATE RECD. BY LOCAL REG. 5-5-59		26. REGISTRAR'S SIGNATURE Neva Marshall	
27. FUNERAL DIRECTOR Passantino Bros		ADDRESS KCMO	

All diseases in Part I must be causally related.

Abraham Galperin USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

M. D.



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 *Leonard Parsonette*

Licensed Embalmer No. *4554*

P. O. Address *K C 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.