

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021209

STATE FILE NUMBER

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3004

300
1-57

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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.

Edward P. Altomare
MEDICAL CERTIFICATION
ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 parking lot 4505 St John		d. STREET ADDRESS 3213 Garner	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK BIONDO		4. DATE OF DEATH Month Day Year 6 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Italy
13a. FATHER'S NAME Frank Biondo		13b. MOTHER'S MAIDEN NAME Francesca Bellina	14. NAME OF HUSBAND OR WIFE Sylvia Biondo
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. 495-20-5480	17. INFORMANT Address Frank Biondo Jr 3707 E 9th K.C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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.) 4200	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from MAY 1959 to JUNE 18 1959 and last saw him alive on JUNE 18 1959 Death occurred at 11:30 A.M. JUNE 19 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward P. Altomare M.D.		22b. ADDRESS 2610 E 63rd ST K.C. Mo.	
22c. DATE SIGNED 6-19-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-22-59	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem		23d. LOCATION (City, town, or county) (State) K.C. Mo.	
24. FUNERAL DIRECTOR ADDRESS SEBBETO'S K.C. Mo.		25. DATE RECD. BY LOCAL REG. 6-20-59	
26. REGISTRAR'S SIGNATURE Neva Minshall			

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 *Forrest D. Coldman*

Licensed Embalmer No. *4714*
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.