

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029213**

**FILED VS SEP 4 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4135 STATE FILE NUMBER

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>  |  | Length of stay in 1b <u>63 yrs</u>  | c. CITY OR TOWN <u>Kansas City</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>         |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <u>132 Brooklyn</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>        |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Katherine</u> Middle <u>Ann</u> Last <u>Montaleone</u>   |  |   | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>23</u> Year <u>59</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>1-21-1896</u>   | 9. AGE (last birthday) <u>63</u>   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>  </u>  | 11. BIRTHPLACE (City and state or country)<br><u>Kansas City, Mo USA</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |  |
| 13a. FATHER'S NAME<br><u>Norris Abbott</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Frances Truglia</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>  </u>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  | 17. INFORMANT Address<br><u>Carl Montaleone Ke Mo</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  | DUE TO (b) <u>acute and old myocardial infarction with hydrothorax and atelectasis</u>  |  |  |   |  |
| DUE TO (c) <u>  </u>  |  |   |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                 |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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<br>Hour <u>  </u> a.m. <u>  </u> p.m.   | Month, Day, Year   |   |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>7-16-59</u>   | and last saw <u>her</u> alive on <u>8-23-59</u>  | Death occurred at <u>10:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                      |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Abraham Galperin</u>   |  |   | 22b. ADDRESS<br><u>2400 Cherry</u>   |  | 22c. DATE SIGNED<br><u>8-25-59</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>8-26-1959</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Elmwood Cem</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Mo</u>  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Kassantus Beoo Ke Mo</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>8-25-59</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Neva Marshall</u>  |  |   |  |

DOCUMENT

BY AFFIDAVIT OF Abraham Galperin M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leonard Rosantierio

Licensed Embalmer No. 453

P. O. Address KE M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.