

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 3 0 1959

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Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6034 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</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>1 yr. 3 mo.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.C.T.B. Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2625 Olive</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle _____ Last <u>Luciano</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wht.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Porto Rico</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Sandolia Luciano</u>			13b. MOTHER'S MAIDEN NAME <u>Marcis</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>081-18-1737</u>		17. INFORMANT Address <u>Thomas Luciano 2538 Park</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u>							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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input 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 Hour _____ a.m. _____ 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>Sep. 1 - 1958</u> to <u>Dec. 13 - 1959</u> and last saw ^{her} him alive on <u>Dec. 13 - 1959</u> Death occurred at <u>5:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) <u>Edward P. Altomare M.D.</u>				22b. ADDRESS <u>K. C. T. B. Hosp.</u>		22c. DATE SIGNED <u>12-15-59</u>		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>12/16/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Manlove-Williams 1729 Lydia</u>			25. DATE RECD. BY LOCAL REG. <u>12-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Edward P. Altomare

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 Raymond Williams

Licensed Embalmer No. 4653

P. O. Address X P

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.