

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046273

FILED VS JAN 11 1961

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6457 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>23 yrs</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>12<sup>th</sup> Highland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>425 S Montgall</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MANUEL</u> Middle <u>PERNICE</u> Last <u>PERNICE</u>			4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>60</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>6-18-1937</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Filippo Pernice</u>		13b. MOTHER'S MAIDEN NAME <u>Herlinda Gloria</u>		14. NAME OF HUSBAND OR WIFE <u>  </u>	
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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>unk</u>	17. INFORMANT <u>Filippo Pernice</u> Address <u>425 S Montgall</u>
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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>Accident - Head Injury</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>  </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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Explosion in fire</u>
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20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>12-22-60</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Garage</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u> COUNTY <u>Jackson</u> STATE <u>MO</u>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. C. R. ...</u> (Degree or title)	22b. ADDRESS <u>627 West ...</u>	22c. DATE SIGNED <u>12-22-60</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>
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24. FUNERAL DIRECTOR <u>Kassantino Bros</u> ADDRESS <u>KC MO</u>	25. DATE RECD. BY LOCAL REG. <u>12.23.60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>
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DOCUMENT MEDICAL CERTIFICATION Keahnoher BY AFFIDAVIT OF

**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 *A. L. Passantino*

Licensed Embalmer No. 4554

P. O. Address Kcm

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.