

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3335-61-025543
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. _____

AMENDED FILED JUL 26 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Milton A. Steinberg
MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|--|--|---|--|------------|--|--|--|
| 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) <u>Kansas City</u> | | Length of stay in 1b <u>17 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>Osteopathic Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>312 N Drury</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>VALENTI</u> Last _____ | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1961</u> | | | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OF RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-30-1888</u> | | 9. AGE (last birthday) <u>72</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <u>Retirement</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) <u>Italy</u> | | | 12. CITIZEN OF WHAT COUNTRY <u>USA.</u> | | | | | | | | |
| 13a. FATHER'S NAME <u>Francisco Valenti</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Francesca Manione</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Santa</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | | | | 17. INFORMANT <u>Santa Valenti</u> Address <u>312 N. Drury</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes _____ | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute circulatory failure</u> | | | | | | | | | | Days _____ | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) <u>Myocardial infarction</u> | | | | Days _____ | | | |
| | | | | | | | | | | DUE TO (c) <u>Coronary occlusion</u> | | | | Days _____ | | | |
| 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 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.) | | | | | | | | | |
| 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>6-16-61</u> to <u>6-2-61</u> and last saw <input checked="" type="checkbox"/> him alive on <u>7-2-61</u> Death occurred at <u>12:25</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Print name or title) <u>Milton A. Steinberg D.O.</u> | | | | | | 22b. ADDRESS <u>926 E. 11th, Kansas City, Mo.</u> | | | | | | 22c. DATE SIGNED <u>7-3-61</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE <u>7-5-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cem.</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Kaunitz Bros</u> | | | | ADDRESS <u>KC Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-4-61</u> | | REGISTRAR'S SIGNATURE <u>Ruth Long</u> | | | | | | | | | |

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 *L. C. Lassantino*

Licensed Embalmer No. 4554

P. O. Address KC 7710.

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.