MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4263 61-029178
STATE FILE NUMBER

AMENDED

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

FILED SEP 8 1961

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY
Length of stay in 1b: 54 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Marys Hospital
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: KANSAS b. COUNTY: WYANDOTTE
c. CITY OR TOWN: KANSAS CITY
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 2729 N. 34th
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle MARIE Last CONIGLIO
4. DATE OF DEATH: Month August Day 27 Year 1961
5. SEX: female
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/6/1917
9. AGE (last birthday): 44
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (City and state or country): Kansas City, Ks
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: John Wolters
13b. MOTHER'S MAIDEN NAME: Elizabeth Krull
14. NAME OF HUSBAND OR WIFE: Ben Coniglio
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.: —
17. INFORMANT: Mr Ben Coniglio Address: 2729 N. 34th K.C.Ks.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Primary carcinoma of cervix — 18 mos
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8-3-60, to 8/27/61 and last saw her alive on 8/27/61
Death occurred at 8:30pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Neill Berry (Degree or title): MD
22b. ADDRESS: 4706 Bdwy. K.C.Mo
22c. DATE SIGNED: 8/28/61

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 8/30/61
23c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Ks.

24. FUNERAL DIRECTOR: JOS. A. BUTLER'S SONS ADDRESS: K.C.K
25. DATE RECD. BY LOCAL REG.: 8-28-61
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

Neill Berry

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3426 Mo.

P. O. Address Kansas City Kan

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.