

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047116

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6355 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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>46 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>St Joseph's Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>2607 Elma</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARMELA</u> Middle <u>PALAZZO</u> Last <u>PALAZZO</u>			4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>62</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20 1886</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY <u>Italy</u>		13a. FATHER'S NAME <u>Antonio Cuilla</u>	
13b. MOTHER'S MAIDEN NAME <u>Josephine</u>		14. NAME OF HUSBAND OR WIFE <u>uncle Antonio Palazzo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Tony Palazzo</u>		Address <u>1042 E 5th</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>CORONARY OCCLUSION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE</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) <u> </u>			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 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.) <u> </u>			
20c. TIME OF INJURY <u> </u> Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u> <u> </u> <u> </u>		
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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>JUNE 1950</u> to <u>DECEMBER 1962</u> last day I gave on <u>DECEMBER 13th</u> Death occurred at <u>11:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Edward P. Altomare</u> (Type name and title)		22b. ADDRESS <u>2610 E 63rd St</u>	
22c. DATE SIGNED <u>12-14-62</u>		22d. SIGNATURE <u> </u>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>	23d. LOCATION (City, town, or county) (State) <u>K.C. Mo</u>
24. FUNERAL DIRECTOR <u>SEBBETO'S</u>	ADDRESS <u>K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-14-62</u>	26. REGISTRAR'S SIGNATURE <u>A. with Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

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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 Forrest D. Caldwell

Licensed Embalmer No. 4714

P. O. Address R. P. W.

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.