

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6623

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. 7511)

Registration District No. 399
Primary Registration District No. 1002

File No. 700
Registered No. 700
St. _____ Ward _____

2. FULL NAME

Angela Genova
(a) Residence. No. 7511 St. _____ Ward 14
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14, 1928

7. AGE YEARS MONTHS DAYS 5 1
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Pietro Genova

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Italy
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Francesca Baron

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Italy
(STATE OR COUNTRY)

14. INFORMANT Pietro Genova
(Address) 7511 Monroe

15. FILED 2-17-29 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-18 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 10, 1929, to Feb 18, 1929 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ A.P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Trenchio Pneumonia

107R (duration) _____ yrs. _____ mos. 25 ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

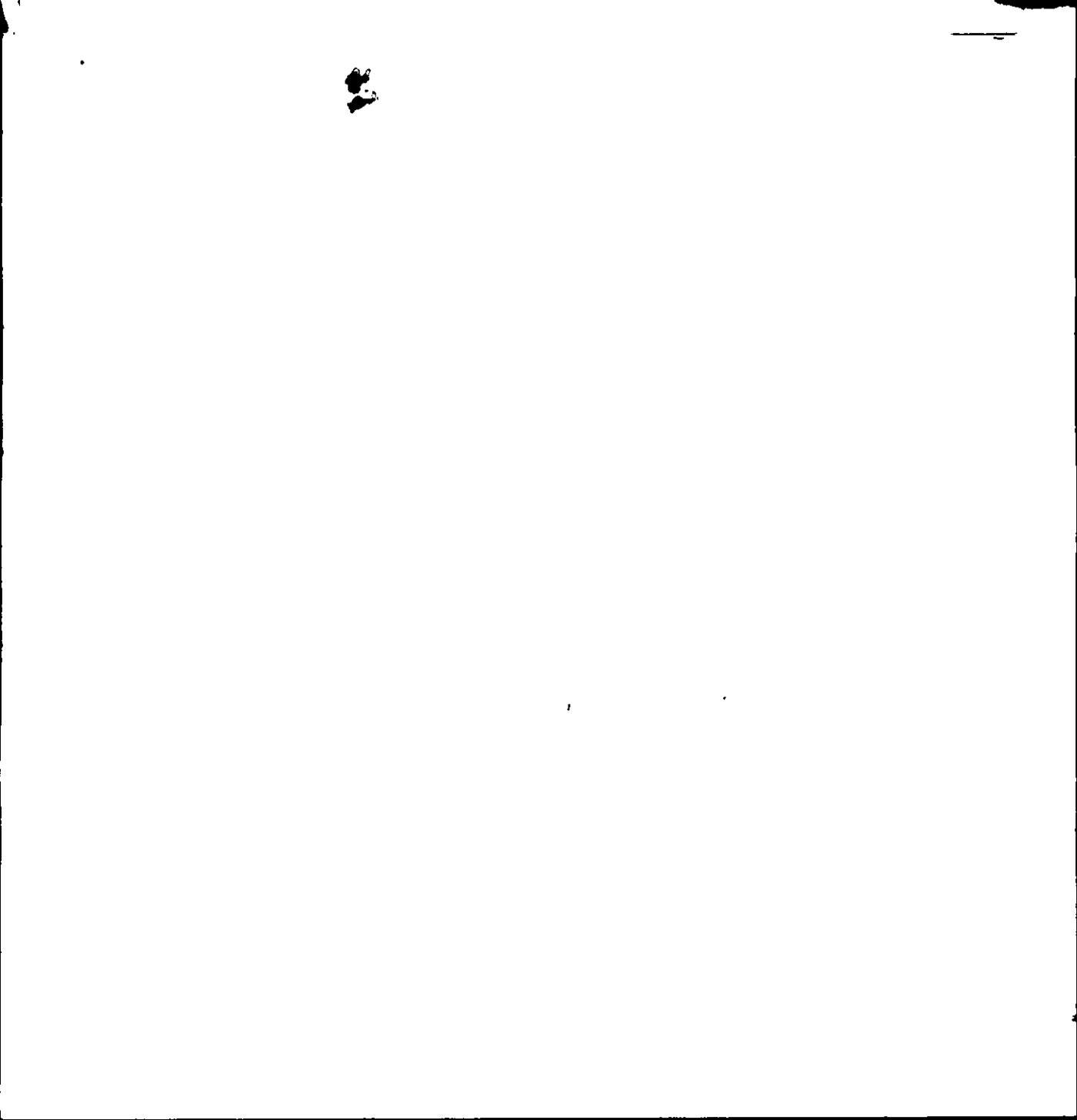
WHAT TEST CONFIRMED _____ non

(Signed) M. D. Druggan, M. D.
2/16, 1929 (Address) 402 Northman Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. St. Marys DATE OF BURIAL 2-18 1929

20. UNDERTAKER A. Sebeto ADDRESS City



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 788
 City W. City (No.) St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT.....
 (Address)

15. FILED 3/17, 1929 M. M. Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1929

17. I HEREBY CERTIFY That I attended deceased from.....
 19..... to....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spontaneous pneumonia
Primary
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)
W
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

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