

REC'D SEP 13 1938

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

28041

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Jackson Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. CC Gen Hosp Registered No. 3352
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Marion Saladin 432
 (a) Residence, No. 423 Olive St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Saladin
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labourer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-23, 193822. I HEREBY CERTIFY, That I attended deceased from 8-21, 1938 to 8-23, 1938

I last saw him alive on 8-23, 1938 Death is said to have occurred on the date stated above, at 5:30 PM
 The principal cause of death and related causes of importance were as follows:

Hypertensive Heart Disease
 Date of onset not

Other contributory causes of importance:

Postoperative Hemorrhage for strangulated Hernia

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) P. J. De Maria, M. D.(Address) St. CC Gen Hosp12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy13. NAME Trasimo Saladin14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy15. MAIDEN NAME Basgena Corpe16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy17. INFORMANT (ADDRESS) Trasimo Saladin
423 Olive St

18. BURIAL, CREMATION, OR REMOVAL

PLACE Int. St. Mary DATE Aug 26, 193819. FUNERAL DIRECTOR (NAME) (ADDRESS) Passantini
CC Gen Hosp20. FILED Aug 24, 1938 M. M. Brown
Local Registrar.

Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1003

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.