

1939 MAR 9

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

5647
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Law Primary Registration District No. 1002
 (c) City Kansas (d) Street No. Research Hospital Registered No. 846
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 312 N. Duxy Ave St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Italian 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 4 - 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 1 19

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Labor
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

FATHER 13. NAME Venanzo Ferrare
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

MOTHER 15. MAIDEN NAME Carmello Barbacid
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

17. INFORMANT Sam Ferrara
 (ADDRESS) 312 N Duxy Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. St. Mary DATE Feb 27 - 39

19. FUNERAL DIRECTOR (NAME) Passantino Bros
 (ADDRESS) 126 W. M. Crowe

20. FILED 2/26 1939 M. M. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/19, 1938, to Feb. 24, 1939

I last saw him alive on Feb. 24, 1939 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia. Date of onset 3 days
108

Other contributory causes of importance:
Recent recoveries from operation Gall stones

Name of operation Cholecystectomy Date of 1/29/39
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? No
 If so, specify _____
 (Signed) T. A. Wilkinson, M. D.
 (Address) 1103 Grand Ave.

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.

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.