

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

**28118**  
 Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township J. Ross Primary Registration District No. 1002  
 (c) City J. C. Mo (d) Street No. St. Mary Hospital Registered No. 3120  
 (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 Sciolaro Sam

(a) Residence, No. 3416 Jackson 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 Sciolaro

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 26 1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
<u>32</u>	<u>8</u>	<u>8</u>	<u>8</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Route Manager  
 9. Industry or business in which work was done, as saw mill, bank, etc. Ronie Bakery  
 10. Date deceased last worked at this occupation (month and year) .....  
 11. Total time (years) spent in this occupation 11 1/2

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

FATHER

13. NAME Joseph Sciolaro  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

MOTHER

15. MAIDEN NAME Berniece Prouh  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

17. INFORMANT (ADDRESS) Rose Sciolaro 3416 Jackson

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary DATE 8/7 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. Lefferts 901 E. 5th

20. FILED 96 1939 M. M. Grove Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4 1939

22. I HEREBY CERTIFY That I attended deceased from August 1, 1939, to August 4, 1939  
 I last saw him alive on August 3, 1939. Death is said to have occurred on the date stated above, at 8:30 A.M.  
 The principal cause of death and related causes of importance were as follows:

1. Meningitis  
 2. Brain abscess

Date of onset 7-29-39

Other contributory causes of importance:  
Emphysema - right  
Regulated gastric ulcer

Name of operation ? Date of ?  
 What test confirmed diagnosis? ..... Was there an autopsy? Yes.

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) R. Johnson MD M. D.  
 (Address) 1420 Professional Building

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.

10 MAR 6 1946

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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.....  
....., 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.**