

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME Infant Ferrara 660

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 11/21/39
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. _____ min.

9. Birthplace K.C. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
 { 12. Name Leo Ferrara
 { 13. Birthplace Kansas City, Missouri
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Grace Presta
 { 15. Birthplace Kansas City, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leo Ferrara

(b) Address 1112 E. Mo. Avenue

17. (a) Burial (b) Date thereof 11 22 39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's Cem

18. (a) Signature of funeral director A. Sebasta

(b) Address 901 E. 5th

19. (a) Nov 23 1939 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21
 year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw him Stillborn alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Stillborn Duration _____

Due to Congenital Talipes Equinovarus

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (Dr. D. or other) _____
 Address _____ Date signed _____

WHILE PLAINLY-USE UNFADING BLACK INK-MAKE A PERMANENT RECORD

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.