DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13755

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 1467

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)

In this community: Unknown

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. 1702 Montgall (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: JOSEPHINE DE BELLA 145

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Eugenio

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: Jan 13 (Month) 1889 (Day) (Year)

8. AGE: Years: 51 | Months: 2 | Days: 20 | If less than one day: ____ hr. ____ min.

9. Birthplace: Italy (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: ?

FATHER

12. Name: Giuseppe Matzzolla

13. Birthplace: Italy (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Vincenzo Capizzo

15. Birthplace: Italy (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Eugenio De Bella

(b) Address: 1702 Montgall

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/5/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt St Marys Cem

18. (a) Signature of funeral director: A Schetz

(b) Address: 901 East 5th St

19. (a) April 4, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 2nd year: 1940 hour: 6 minute: 55 A. M.

21. I hereby certify that I attended the deceased from 3-31-40, 19__, to 4-2-40, 19__; that I last saw her alive on 4-2-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: CEREBRAL HEMORRHAGE	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: None	

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: R. F. De Marra M.D. (M. D. or other)

Address: Supt. K.C. Gen. Hosp., K.C. Mo. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

WRITE 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.

Rev. 5-17-39 I X19511

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 Ray E Snow

Licensed Embalmer No. 2560

P. O. Address 1807 Eck 29

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.