

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13898

Registration District No. 399

Primary Registration District No. 1002

State File No.

Registrar's No. 1640

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:
541 Tracy
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 17 yrs
years, months or days)

3. (a) PRINT FULL NAME ROSE MARRONE 657

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Tony Marrone 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years about 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Housewife

MOTHER FATHER { 12. Name Raffaella Delpuscio 13. Birthplace Italy
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Rose Delpuscio 15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Santore

(b) Address 539 Mahony

17. (a) Burial (b) Date thereof 4/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 901 E 5th

19. (a) April 15, 1940
(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. 541 Tracy
(If rural, give location)
 (e) If foreign born, how long in U. S. A. 47 yrs years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13 year 1940 hour _____ minute 8am

21. I hereby certify that I attended the deceased from Mar 31, 1940, to April 13, 1940, that I last saw her alive on April 12, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
Coronary Heart Disease 14 days

Due to _____
 Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

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 Dr. J. J. Johnson (M. D. or other) _____
 Address 1103 E. 15th St. Wm. N. Mr. Date signed 4-14-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

Roy C. Snow

Licensed Embalmer No. 2520

P. O. Address 1807 East 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.