

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 399

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Garrison Square 4th & Troost  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution life (Specify whether)

In this community  
years, months or days

3. (a) PRINT FULL NAME JOHN GILLOTTI 430

3. (b) If veteran, name war no 3. (c) Social Security N495-05-4013

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

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

7. Birth date of deceased Sept. 22 — 1913  
(Month) (Day) (Year)

8. AGE: Years 26 Months 7 Days 296 If less than one day  
hr. min.

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

10. Usual occupation Hotel Service

11. Industry or business \_\_\_\_\_

12. Name Patsy Gigliotti

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

14. Maiden name Frances Noto

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

16. (a) Informant Sam Pascuzzi

(b) Address 511 Troost

17. (a) burial (b) Date thereof 5/22/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 901 E 5th

19. (a) May 20, 1940 (b) M. M. Browne  
(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. 321 Troost (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day 5-19-40  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 4:30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and \_\_\_\_\_ occurred on the date and hour stated above.  
Immediately cause of death \_\_\_\_\_

stab wound of l. chest  
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Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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) Homicide  
(b) Date of occurrence 5-19-40  
(c) Where did injury occur? K.C. Mo  
(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)  
(Specify type of activity)

23. Signature Walter B. ... (D. or other)  
Address K.C. Mo. Date signed \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.....

*Roy E. Snow*  
.....  
Licensed Embalmer No. *2560*

P. O. Address *1807 East 29th*

**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.**