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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30887
Registrar's No. 3450

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 510 Harrison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 months (Specify whether years, months or days)

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. 510 Harrison
(If rural, give location)
(e) If foreign born, how long in U. S. A. 55 years.

3. (a) PRINT FULL NAME Michael Scaletta
Michael Scaletta

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 106 1/2 years

7. Birth date of deceased: May (Month) 1864 (Day) (Year)

8. AGE: Years 76 Months 3 Days Unk If less than one day hr. min.

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

10. Usual occupation: Retired Grocer

11. Industry or business: Scaletta

12. Name: Italy (City, town, or county) (State or foreign country)

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

14. Maiden name: Donna

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

16. (a) Informant A. Scaletta
(b) Address 3315 Baker

17. (a) Removal (b) Date thereof 9/1/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth Park
(d) Signature of funeral director J. D. D'Onofrio
(e) Address Leavenworth Park

19. (a) Sept. 3, 1940 (Date received local registrar) M. M. Grome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1st year 1940 hour 3:30 minute a M.

21. I hereby certify that I attended the deceased from Aug 31 1940 to Sept 1 1940; that I last saw alive on Aug 31 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion Duration 3 hrs.

Due to: 1st

Due to: 1st

Other conditions: Heart Disease

Major findings: Myocardial Infarction

Of operations: None

Of autopsy: None

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? _____

23. Signature: Louis Scarpellino (Specify type of place) (e) Means of injury: 1st
Address: 877 Arroyo Blvd (M. D. or other) MD
Date signed: Sept 3-40

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.