

No. 2
-4-41
17-39
X26390

DEPARTMENT OF COMMERCE.
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33944**
3981
Registrar's No. _____

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 **Hannas City**
(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 _____
In this community **40 years 0** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Hannas City** **041**
(If outside city or town limits, write "RURAL")
(d) Street No. **511 Holmes St**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **16**
year **1941** hour **8** minute **10 AM**
21. I hereby certify that I attended the deceased from **Sept. 25, 1941**
to **Oct. 16, 1941**
that I last saw him alive on **October 16, 1941**
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME **Anthony Marra**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

Immediate cause of death **Bronchial Pneumonia** Duration _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Catherine Marra** 6. (c) Age of husband or wife if alive **27** years
7. Birth date of deceased **July 24 1892**
(Month) (Day) (Year)

Due to **Thrombo-embolic disease: pulmonary Thrombosis.**

8. AGE: Years **49** Months **2** Days **22** If less than one day _____ hr. _____ min.

Due to **107**

9. Birthplace **Philadelphia Penn**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Shoe Repair**

Major findings: **none**
Of operations _____

11. Industry or business _____

Of autopsy **none**

12. Name **Angelo Marra**

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

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

14. Maiden name **Alegandru Santora**

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

16. (a) Informant **Pros Carella**

(b) Address **1513 Myrtle**

17. (a) **Burial** (b) Date thereof **Oct 18 - 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Marys**

18. (a) Signature of funeral director **Pasanti's Bros**

(b) Address **10/17/41** (c) **M. C. Crow**
(Date received local registrar) (Registrar's signature)

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 **M. J. Fedward** (M.D. or other) **0**
Address **1618 Professional Bldg.** Date signed **10/18/41**

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 Carl Rowe
Licensed Embalmer No. 2347
P. O. Address K C MO

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.