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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 31 1941

Registration District No. 400

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 55-5-313

State File No. 42123

Registrar's No. 153

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

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: Jackson County Home for the Aged & Infirm
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs 7 mo (Specify whether years, months or days)

In this community 10 years

8. (a) PRINT FULL NAME James Ballotti

8. (b) If veteran, name war ✓

8. (c) Social Security No. ✓

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 11 (Day) 1867 (Year)

8. AGE: Years 74 Months 7 Days 14 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant Records Jackson County Home

(b) Address Lee's Summit Mo

17. (a) Lee's Summit (Burial, cremation, or removal) (b) Date thereof 9-26-41 (Month) (Day) (Year)

(c) Place: burial or cremation Lee's Summit Mo

18. (a) Signature of funeral director N. B. Langford

(b) Address Lee's Summit Mo

19. (a) 10-1-41 (Date received local registrar) (b) Sara G. Gaines (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 523 Grand 8
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 25 year 1941 hour 2 minute a M.

21. I hereby certify that I attended the deceased from July 1, 1941, to 9-25, 1941, that I last saw h— alive on 9/24, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 93d

Major findings:
Of operations

Of autopsy

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 J. W. Greene (M. D. or other)

Address 2 Dr Department Date signed 9-27-41

732 (Licensed Embalmer's Statement on Reverse Side) Mo

## 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 complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**