

**FILED MAR 27 1946**  
Registration District No. **147**

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 **Kennett City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**569 Campbell St**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **unknown**  
years, months or days

3. (a) PRINT FULL NAME **Domenico Senone**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **427-09-5419**

4. Sex **male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Antonia Senone** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Sept 8 1879**  
(Month) (Day) (Year)

8. AGE: Years **66** Months **6** Days **7** If less than one day hr. min.

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

10. Usual occupation **Bartender**

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

MOTHER FATHER

12. Name **Pat Senone** 5

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

14. Maiden name **Mary Sant'Angela**

15. Birthplace **Italy** 5  
(City, town, or county) (State or foreign country)

16. (a) Informant **Pat Senone**  
(b) Address **328 Brooklyn**

17. (a) **Burial** (b) Date thereof **3/18/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **mt St Mary**

18. (a) Signature of funeral director **Paucilio Via**  
(b) Address **Kennett City Mo**

19. (a) **3-16-46** (b) **Thereldine Holmes**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson** 48  
(c) City or town **Kennett City Mo** 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. **569 Campbell St** 8  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **15**  
year **1946** hour **9** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **13 Mar 1945** to **15 Mar 1946**  
that I last saw him alive on **14 Mar** and that death occurred on the date and hour stated above.

Immediate cause of death  
**Bronchial Asthma** 246  
Due to **Cardiac Failure**

Due to **Cardiac Decompensation**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **none** 956  
Of autopsy **none** 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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **Marlene Hunter** M. D. or other \_\_\_\_\_  
Address **114 Main** Date signed **16 Mar 46**

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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 J. S. Walton

Licensed Embalmer No. 2944

P. O. Address H. C. Mo

**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, fact should be so stated above.**