

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8071

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. General Hosp)

Registration District No. 329
Primary Registration District No. 00

File No. _____
Registered No. 923
St. _____ Ward _____

2. FULL NAME

Alongo, Peter

(a) Residence. No. 2210 Alma St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-29-1915

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11 2 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Alongo, Marino

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Italy

12. MAIDEN NAME OF MOTHER Saladino, Jennie

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Italy

14. INFORMANT (Address) Record Clerk K. C. General Hosp

15. FILED Mar 4, 1927 M. M. Crowl REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-3 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-16, 1927, to 3-3, 1927 that I last saw h. s. a. l. alive on 3-3, 1927, and that death occurred, on the date stated above, at 2:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac decompensation with chronic interstitial nephritis 191

CONTRIBUTORY (SECONDARY) 129W

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

18 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) George C. Lee, M. D.
3/4, 1927 (Address) K. C. General Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

int. to morg Mar 4, 1927

20. UNDERTAKER ADDRESS

A. Schlecter 901 East 5th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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