

AUG 16 1927

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

Do not use this space.

20970

1. PLACE OF DEATH

County... Clay Registration District No. 198 File No.
 Township... Excelsior Springs, Mo. Primary Registration District No. 3011 Registered No. 81
 City... Excelsior Springs, Mo. St. Ward)

2. FULL NAME Andrea Passanette (Andrea Passanette)

(a) Residence. No. U.S. Vets. Hosp. Excelsior Springs, Mo. Ward. Omaha, Neb.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U.S., if of foreign birth? 16 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-26-1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
36	6	14		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer Common
 (b) General nature of industry, business, or establishment in which employed (or employer) Don't know
 (c) Name of employer Don't know

9. BIRTHPLACE (CITY OR TOWN) Italy
(STATE OR COUNTRY)10. NAME OF FATHER Pete Passanette11. BIRTHPLACE OF FATHER (CITY OR TOWN) Italy
(STATE OR COUNTRY)12. MAIDEN NAME OF MOTHER Sarah Tetona13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Italy
(STATE OR COUNTRY)

14.

INFORMANT Diseased
(Address) Andrea Passanette

15.

FILED 7/10 27 yd. Craun
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10, 1927. 19

17. I HEREBY CERTIFY, That I attended deceased from 9-10-25 to 9-10-25, 1927, to July 10, 1927, 1927, that I last saw him alive on 7-10-27, 1927, and that death occurred, on the date stated above, at 6-30 A.M. am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(A) Pulmonary Congestion

(B) Chronic Myocarditis, Cardiac Hypertrophy, Mitral Regurgitation.
 (duration) 4 yrs. 5 mos. 21 ds.

18. WHERE WAS DISEASE CONTRACTED (A) Excelsior Springs, Mo.IF NOT AT PLACE OF DEATH? (B) Unknown

DID AN OPERATION PRECEDE DEATH? NO. DATE OF

WAS THERE AN AUTOPSY? NoWHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs(Signed) T.F. Neil, M. D.7-10-1927 (Address) Excelsior Springs, Mo.

*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

Crown Hill Ex Spgs. 7-11-27
 20. UNDERTAKER ADDRESS

Herbert Hope, Excelsior Springs, Mo.

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.

