

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

Do not use this space.

30424

1. PLACE OF DEATH

County Jackson Registration District No. 1002
 Township Hannas city Primary Registration District No. _____
 City Hannas city (No. 548, Holmes) St. _____ Ward _____

File No. _____
 Registered No. 3931

2. FULL NAME

Calogera Mandino
 (a) Residence. No. 548 Holmes St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8-27

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>7</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) none
 (c) Name of employer _____

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

10. NAME OF FATHER Tommaso mandino

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

12. MAIDEN NAME OF MOTHER Maria Romano

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hannas city
 (STATE OR COUNTRY) Missouri

14. INFORMANT Tommaso mandino
 (Address) 548 Holmes

15. FILED 10-18-27 M. M. Crave
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-17-27

17. I HEREBY CERTIFY, That I attended deceased from 18-14, 1927, to 10-17, 1927, that I last saw her alive on 10-17, 1927, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital Heart Lesion
1870
158

CONTRIBUTORY Exhaustion
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 8/15/27
 IF NOT AT PLACE OF DEATH. DATE OF _____
 DID IN OPERATION PRECED DEATH. DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Carlo Jackson, M. D.
10-18-27 (Address) 573 Commerce St

*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 St. St. Mary DATE OF BURIAL 10-18-27

20. UNDERTAKER A. Schute ADDRESS city

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.

