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

Do not use this space.

17070

1. PLACE OF DEATH
County Jackson — Registration District No. ..... — File No. 2039
Township Kaw — Primary Registration District No. ..... — Registered No. .....
City Kansas City, Mo (No. General Hospital ..... St. ..... Ward)

2. FULL NAME Lipari Anna
(a) Residence. No. 1115 E. 5th St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
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) 3-21-1928

7. AGE — YEARS: — MONTHS: 2 — DAYS: 16 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(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 Tony Lipari
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy
12. MAIDEN NAME OF MOTHER Rosie Bokata
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

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

15. FILED 5-7, 1928 M M Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-7- 1928

17. I HEREBY CERTIFY, That I attended deceased from 5-5, 1928, to 5-7, 1928, that I last saw her alive on 5-7, 1928, and that death occurred, on the date stated above, at 5:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Whooping Cough
9 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) P. E. Wiggins, M.D.
5/7, 1928 (Address) K.C. General Hospital

*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: Elmwood — DATE OF BURIAL: May 8 1928

20. UNDERTAKER: A. Sebbets — 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD