

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

Do not use this space.

36878

1. PLACE OF DEATH

County Jackson Registration District No. _____

Township How Primary Registration District No. _____

City Kansas city (No. 820 East 9th) St. _____ Ward _____

File No. 4738

Registered No. 4738

2. FULL NAME

(a) Residence. No. 4405 N. John Ward 10
(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 m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE Gene Rossantino

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>23</u>			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

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

10. NAME OF FATHER Joe Rossantino

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

12. MAIDEN NAME OF MOTHER Caterina Xola

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

14. INFORMANT Joe Rossantino
(Address) 4405 N. John

15. FILED 11/9/38 M. M. Crowe REGISTRAR
Asor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 1928

17. I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Carbolic Acid
a poison

16 1/2 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 66
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Deputy Coroner

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. St. Marys DATE OF BURIAL 11-8 1928

20. UNDERTAKER A. Sebeto ADDRESS K.C. 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.

