

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

Do not use this space.

6600

1. PLACE OF DEATH

County Jackson
Township Kearney
City Kansas City (No. 566 Harrison)

Registration District No. 399
Primary Registration District No. 1002

File No. 6765
Registered No. 6765 St. Ward

2. FULL NAME

Gena Gaspari
(a) Residence. No. 566 Harrison 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) Oct 1926

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2

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) nurs
(c) Name of employer nurs

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

10. NAME OF FATHER Andrew Gaspari

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

12. MAIDEN NAME OF MOTHER Marie Benegato

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

14. INFORMANT Andrew Gaspari
(Address) 566 Harrison

15. FILED 2-15-29 M M Come Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1929, to Feb 12, 1929 that I last saw her alive on Jan 27, 1929, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Labor Pneumonia
IOB

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, 566 Harrison

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) W. J. Hollister M. D.

(Address) 737 Lathrop Ave

*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 Mt. St. Mary's DATE OF BURIAL 2-16 1929

20. UNDERTAKER A. Sebeto ADDRESS K City, 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.

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

W. A.—Every item of information should be...
OF DEATH in their series...
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OF DEATH in their series...
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OF DEATH in their series...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 765-

City R. City (No.) St. Ward)

2. FULL NAME

(a) Residence. No. 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>W</u> (write the word)
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6 1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>2</u>	<u>4</u>	<u>8</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(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)

PARENTS

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT.....
(Address)

15. FILED 7/15 29 M M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration)..... yrs..... mos..... ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
....., 19..... (Address)

*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
	19

20. UNDERTAKER	ADDRESS

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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-6600