

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

Do not use this space.

10860
10513

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Haw Primary Registration District No. _____
 City Kansas City (No. Kansas City Genl Hosp St. _____ Ward)

File No. _____
 Registered No. 1370

2. FULL NAME

Rosa Charles
 (a) Residence. No. Portland Hotel St. _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Divorced
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27, 1894

7. AGE		MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
YEARS				
<u>37</u>	<u>11</u>		<u>20</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Labourer
 (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) Illinois

10. NAME OF FATHER Joe Rosa

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

12. MAIDEN NAME OF MOTHER Katherine

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

14. INFORMANT (Address) Reverend Clerk Kansas City Genl Hosp

15. FILED 3/19, 1929 11. M. Cassner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 1929

17. I HEREBY CERTIFY That I attended deceased from 3-8, 1929 to 3-11, 1929 that I last saw him alive on 3-11, 1929 and that death occurred, on the date stated above, at 4:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of lungs

CONTRIBUTORY (SECONDARY) 31 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clin + Lab Find
 (Signed) P. Williams M. D.

3-17, 1929 (Address) Subt 7-C Genl Hosp

*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. Mary's **DATE OF BURIAL** 3/19 1929

20. UNDERTAKER W. M. St. **ADDRESS** 1915 East 75

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.

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