

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

Do not use this space.
33911

4364

1. PLACE OF DEATH

County Jackson
Township Kaw
City R.C.Mo

Registration District No. 305
Primary Registration District No. 1002
(No. 801 Park Ave)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Vita Leone
(a) Residence. No. 801 Park Ave, St. 9 Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Andrea Leone

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 1 - 1854

8. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 11 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Imperia
(STATE OR COUNTRY) Italy

10. NAME OF FATHER Stephen Stassi

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

12. MAIDEN NAME OF MOTHER Maria Gentile

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

14. INFORMANT Stephen Leone
(Address) 801 Park Ave. R.C.Mo

15. FILED 10/23, 1929 M. M. Crowe
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-20, 1929

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1929 to Oct 20, 1929, that I last saw him alive on Oct 19, 1929, and that death occurred, on the date stated above, at 9.50 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

936 Biliary Calculi
126

CONTRIBUTORY (SECONDARY) Myocardial fatty degeneration
(duration) 1 yrs. 7 mos. 2 ds.

(duration) 2 yrs. 0 mos. 0 ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Examination
(Signed) A.P. Lauranzana, M. D.
10/21, 1929 (Address) K 6 Mo

*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 Oct-23 1929

UNDERTAKER A. Roberto City, Mo
ADDRESS _____

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.

MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

John Jones

BR

1875
1876
1877