

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

Do not use this space.

5177

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 835
 Township Kaw Primary Registration District No. 1002 Registered No. 835
 City Kansas City (No. Mercy Hosp) St. _____ Ward _____

2. FULL NAME

Henry Midena
 (a) Residence No. 7-39 Cherry St. 1 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 m 4. COLOR OR RACE W 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) Dec. 21 1929

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

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER John Midena

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

12. MAIDEN NAME OF MOTHER Leina Papundi

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

14. INFORMANT John Midena
 (Address) 739 Cherry

15. FILED 7/23 1930 M.M. Crowe
 REGISTRAR Ans

MEDICAL CERTIFICATE OF DEATH

18. DATE OF DEATH (MONTH, DAY AND YEAR) 2-22 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-22 1930, to 2-22 1930 that I last saw him alive on 2-22 1930 and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
157A
158 (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED 1000
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. E. Dinger, M. D.

2/22 1930 (Address) Mercy Hosp

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. St Marys DATE OF BURIAL 2/24 1930

20. UNDERTAKER A. Sebeto ADDRESS 190 C. Mrs.

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.

