

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

Do not use this space.

12845

1. PLACE OF DEATH

County Jackson
Township East
City Leeds

399

Registration District No. _____
Primary Registration District No. 1002
(No. Leeds Hospital)

File No. _____
Registered No. 18774
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 5829 E. 9th St. 10 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>Female</u>	4. COLOR OR RACE <u>Italian</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20, 1911

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>18</u>	<u>9</u>	<u>1</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundry Helper
(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) Italy

10. NAME OF FATHER

Joe Cuda

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Italy

12. MAIDEN NAME OF MOTHER

Mary Boneore

BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Italy

ORMANT Records of Leeds Hospital.
address Leeds, Mo.

FILED 4/23 31 M.M. Crover
19 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-21 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1929 to April 21, 1930 that I last saw her alive on 4-21, 1930, and that death occurred, on the date stated above, at 8:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

229 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Microscopical

(Signed) George C. Bell M.D.
4/27 1930 (Address) 1002 Maple Blk. R.C. 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

DATE OF BURIAL

St. Mary's

4-24 1930

20. UNDERTAKER

ADDRESS

A. Sebbeto

R.C. Mo.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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PARENTS

11. 2. 1965

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