Mr 4867

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

Do not use this space.

1. PLACE OF DEATH

County Jackson — Registration District No. — File No. 29845

Township Kaw — Primary Registration District No. — Registered No. 3650

City Kansas (No. Evangelical Hospital St. Ward)

2. FULL NAME Vito Farrara Evangelical Hospetal

(a) Residence. No. 414 Olive 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
45		—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ice Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Antonino Farrara

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

12. MAIDEN NAME OF MOTHER Vita Bondorfa Sept 4, 1930

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

14. INFORMANT Tony Farrara (Address) 521 Harrison

15. FILED 9/5, 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1930

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930 to Sept 3, 1930 that I last saw him alive on Sept 3, 1930 and that death occurred, on the date stated above, at 1.10 P. m.

194E THE CAUSE OF DEATH* WAS AS FOLLOWS:

36

69

Septic Infection of L. Hand and Arm (duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (SECONDARY) Acc dosis & injury to hand means of injury unknown. (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 414 Olive

2 DID AN OPERATION PRECEDE DEATH? yes DATE OF July 30 & Aug 10

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Lab.

(Signed) Th. Elmo Bowden M. D.

Sept 4, 1930 (Address) 601 Bethrop Bld

*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
Mt. St. Mary Cemetery	Sept 6 1930
20. UNDERTAKER	**ADDRESS**
Passantino Bros	2117 Indep Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated ... SICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Was the acido-
sis Diabetic
or Non-Diabetic?
Septic

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

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. 3650

City K. City (No. ....., ... St. ..... Ward)

2. FULL NAME Vito Ferrara

(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. 1 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) M

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

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

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

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)

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)

PARENTS

14. INFORMANT .....
(Address)

15. FILED 9/5, 1930 M. M. Cerone
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1930

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) Acidosis & injury to hand .....(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

SUPPLEMENTARY

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