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

Do not use this space.

30039

File No. 3845

Registered No.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

County: Jackson

Township: Kaw

City: Kansas City (No. Trinity Lutheran Hospital St. Ward)

2. FULL NAME: Baby Calomino

(a) Residence. No. Trinity Lutheran St. Hospital Ward.
(Usual place of abode) 110 N. Askew

(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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 8 hrs. or 3 min.
	—	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(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) Mo

PARENTS

10. NAME OF FATHER Victor Calomino

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

12. MAIDEN NAME OF MOTHER Rose Melson

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

14. INFORMANT Victor Calomino
(Address) 110 N Askew

15. FILED 9-20, 1930 M M Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930 to Sept 20, 1930 that I last saw h alive on Sept 20, 1930 and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
7 months
159

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(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) Carl Gibson, M. D.

9-20, 1930 (Address) 5718 Cosmo Bldg

*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

DATE OF BURIAL: Sept 20 1930

20. UNDERTAKER: Parsanting Bros.

ADDRESS: 2117 Indy. Ave

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD