

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

Do not use this space

30197

**1. PLACE OF DEATH**

County Jackson  
Township Rox  
City K. C. Mo. (No. 517 Gillis)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 4016  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Luigi Zaro  
(a) Residence No. 517 Gillis St. 1 Ward. \_\_\_\_\_

(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
54 3 16

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Western Terrazzo  
(b) General nature of industry, business, or establishment in which employed (or employer) Mosiac Co  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Sebastiano Zaro

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

12. MAIDEN NAME OF MOTHER Maria Brescenzino

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

14. INFORMANT Sam Zaro (Address) 517 Gillis St. K. C. Mo.

15. FILED 10/2 30 M. M. Browne REGISTRAR Asst

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 30 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Sept 30, 1930 that I last saw him alive on Sept 30, 1930, and that death occurred on the date stated above, at 5 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Brain Endocarditis  
urthoacute dilatation  
of heart  
91A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 95B (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS 10/ (Signed) P M Ryan M. D.

\*State the DISEASE CAUSING DEATH, or in death 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 10/2 1930

20. UNDERTAKER C. Sebbeto ADDRESS K. C. Mo.

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

OFFICE PHONE  
VICTOR 8154

RESIDENCE PHONE  
DELAWARE 1873

**A. SEBETO**

**UNDERTAKER & FLORIST**

901 EAST 5TH STREET

KANSAS CITY, MISSOURI

*ast 5-1930*

*by order of J. M. Nigro*

*please make this change.*

*mistake as being made in case at*

*death*

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

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**1. PLACE OF DEATH**

County Jac. Mo. Co. Registration District No. \_\_\_\_\_  
 Township Mo. Co. Primary Registration District No. \_\_\_\_\_  
 City Kansas City (No. 517) Gillis St St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

Guigi Garas  
 (a) Residence, No. 517 Gillis St St. \_\_\_\_\_ 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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND 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) Italy  
 (STATE OR COUNTRY)

10. NAME OF FATHER Sebastian Garas

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

12. MAIDEN NAME OF MOTHER Maria Brescurin

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

14. INFORMANT Sam Garas  
 (Address) 517 Gillis St

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 - 19 30

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:**

acute Dilatation Heart

CONTRIBUTORY acute Endocarditis  
 (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) \_\_\_\_\_, M. D.

\*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 marye DATE OF BURIAL oct 2 - 19 30

20. UNDERTAKER d. schlecto ADDRESS city

Every item of information should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms. PHYSICIAN state EXACTLY. Exact statement of OCCUPATION.