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

Do not use this space.

33202

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 1442

Township: Kaw — Primary Registration District No.: 2002 — Registered No.:

City: Kansas city — (No. st Joseph Hospital St. ..... Ward)

2. FULL NAME Infant Agrusa

(a) Residence. No. 330 Park ave St., 9 Ward. (If nonresident, give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 29 1930

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: non
(b) General nature of industry, business, or establishment in which employed (or employer): non
(c) Name of employer: non

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

PARENTS
10. NAME OF FATHER: Nick Agruse
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Italy
12. MAIDEN NAME OF MOTHER: Mary Santoro
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): missouri

14. INFORMANT: Nick Agruse
(Address) 330 Park ave

15. FILED 11 3 1930 M M Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1930

17. I HEREBY CERTIFY, That I attended deceased from 10/29, 1930, to 10/29, 1930, that I last saw him alive on 10/29, 1930, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature (6 mo) 159 fetus.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 16 ta

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
9 DID AN OPERATION PRECEDE DEATH? — DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [signature], M. D.
10/30, 1930 (Address) 1032 Prof 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	DATE OF BURIAL
mt. st. Marys	Oct 30 1930
20. UNDERTAKER	**ADDRESS**
A. Sebleto	city

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.