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

Do not use this space.

File No. 36209
Registered No. 4615

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: K.C. (No. 2805 E. 7th St. Ward)
Registration District No. 399
Primary Registration District No. 1002

2. FULL NAME: Tom Massucci
(a) Residence. No. 2805 E. 7th 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. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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: Mary Massucci
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 22-1892
7. AGE: 37 Years 1 Months 8 Days 21 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerical
(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): Irpina Voltura Italy
PARENTS
10. NAME OF FATHER: Sarquilio Massucci
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Irpini Voltura Italy
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY):
14. INFORMANT: Widow Mary Massucci
(Address) 2805 E. 7th
15. FILED 11/14 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 13 1930
17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov. 13, 1930 that I last saw him alive on Nov. 12, 1930 and that death occurred, on the date stated above, at 10 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
9.5A (right lower lob.)
108 (duration) yrs. mos. 6 ds.
CONTRIBUTORY (SECONDARY) Tuberculosis of lungs
several (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Dr. J. Wolf, M. D.
Nov. 14, 1930 (Address) 620 Argyle 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 Marys — DATE OF BURIAL: 11/15 1930
20. UNDERTAKER: Peter B. Lafferty — ADDRESS: K.C.

Be sure that all items are properly answered. Write plainly. Exact statement of OCCUPATION is very important. PHYSICIANS should state DISEASE EXACTLY.

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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. 4615

City X-City (No. ....., ... St. ..... Ward)

2. FULL NAME Tom Massucci

(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. 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)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22-1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
X	37	X	8	21

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)

PARENTS

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)

14. INFORMANT .....
(Address)

15. FILED 11/14 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 13 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) .....

..... (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

N. B.—Every item of information should be carefully supplied. [illegible] should be [illegible] EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH [illegible] Exact statement of OCCUPATION is very important.

IS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-36209