

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

Do not use this space.

18186

1. PLACE OF DEATH

County Jackson Registration District No. 389
Township Kaw Primary Registration District No. 1002
City Kansas (No. 204 Wabash)

File No. _____
Registered No. 670008
St. _____ Ward) _____

2. FULL NAME

Marie Ciarelli
(a) Residence. No. 204 Wabash St. 9 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Ciarelli</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>4-24-1887</u>		
7. AGE YEARS <u>41 1/2</u>	MONTHS <u>-</u>	DAYS <u>28</u>
IF LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife
(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) It

PARENTS	10. NAME OF FATHER <u>Tony Fusco</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Italy</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Rosa Massana</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Italy</u> (STATE OR COUNTRY)

14. INFORMANT John Ciarelli
(Address) 204 Wabash

15. FILED May 24, 1931 M. M. Brown
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-22-1931
17. I HEREBY CERTIFY, That I attended deceased from June 6, 1931, to May 22, 1931 that I last saw him alive on May 22, 1931 and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Septic Endocarditis
1157
9177
CONTRIBUTORY (SECONDARY) acute septic tonsillitis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Tonsillar tonsy
IF NOT AT PLACE OF DEATH _____

2 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5-22-31
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) W. H. Nelson M. D.

5-22-1931 (Address) 1200 Prof Bldg
*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 Mt. St Mary Cemetery DATE OF BURIAL 5-25-1931

20. UNDERTAKER Passantino Bros ADDRESS J. C. Mo.

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

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.

