

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

30556

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township St Joseph Mo Primary Registration District No. 1002
City St Joseph Mo (No. State Hosp # 2)

File No. _____
Registered No. 917
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1359 Garrison Kansas City, Mo St. Kansas City Mo Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 11 6

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 Mo
(STATE OR COUNTRY)

10. NAME OF FATHER John Duccio
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Brooklyn Missouri
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Gladys Benedict
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Springton Lexington Mo
(STATE OR COUNTRY)

14. INFORMANT State Hospital Records #2
(Address) St Joseph, Mo

15. FILED 9-10-31 John R Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4 1931
17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1931 to Sept 4 1931, that I last saw him alive on Sept 4 1931, and that death occurred, on the date stated above, at 11:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Juvenile Paralysis
83 Over (duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (SECONDARY) 83 Over (duration) yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Calypso Smith M. D.
Apr 5, 1931 (Address) State Hospital # 2 St Joseph Mo

*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 State Hospital Bur DATE OF BURIAL Sept 10 1931

20. UNDERTAKER Fred D Clark ADDRESS 6035 King Hill

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.

Oct 28 1931

