

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. 10) St. Vincent Park Hospital

Registration District No. 30  
Primary Registration District No. \_\_\_\_\_

File No. 8325  
Registered No. 895  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mattie Casala  
(a) Residence. No. 529 Cherry 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62      2      unk

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Italy 16  
(STATE OR COUNTRY)

10. NAME OF FATHER Faustino Casala

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

12. MAIDEN NAME OF MOTHER Camilla Cancellari 3, 1932 (Address) 609 Cambridge

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

14. INFORMANT Faustino Casala  
(Address) 521 Halcyon

15. FILED 3/3 1932 M. M. Brown REGISTRAR  
Assn

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1, 1932

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1931 to Mar 1, 1932  
that I last saw him alive on 3-1-1932, and that death occurred, on the date stated above, at 11 P.M. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronchopneumonia  
9 1/2 hr (duration) yrs. mos. 4 ds.  
CONTRIBUTORY 107A Mental Regression (SECONDARY)  
(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED U.S. - no  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no (D)

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
(Signed) J. S. Sheldon 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 Mount St Mary 3/4 1932  
DATE OF BURIAL

20. UNDERTAKER A. Sebete ADDRESS 901 E 5

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.

