

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

Do not use this space.

24879

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township North Primary Registration District No. 100
 City Kansas (No. 707 E 5th) St. _____ Ward _____

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

2. FULL NAME

Nancy LaBella
 (a) Residence, No. 707 E 5th 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 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) July 10 1924
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
10 — 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. child
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo

13. NAME John LaBella

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo

15. MAIDEN NAME Rose Cuccia

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT (ADDRESS) George Pasantino
2117 19th Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. St Mary Cemetery DATE July 28-34

19. UNDERTAKER (ADDRESS) Pasantino Bros
2117 19th Ave

20. FILED 7-29-34 m. m. Corow
Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25 1934
 22. I HEREBY CERTIFY That I attended deceased from 4-1 1930 to July 25 1934
 I last saw h^er alive on July 24 1934 Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:

Ac. Internal hydrocephalus
876
 Other contributory causes of importance
none

Name of operation _____ Date of _____
 What test confirmed diagnosis? Phys. find. Was there an autopsy? No

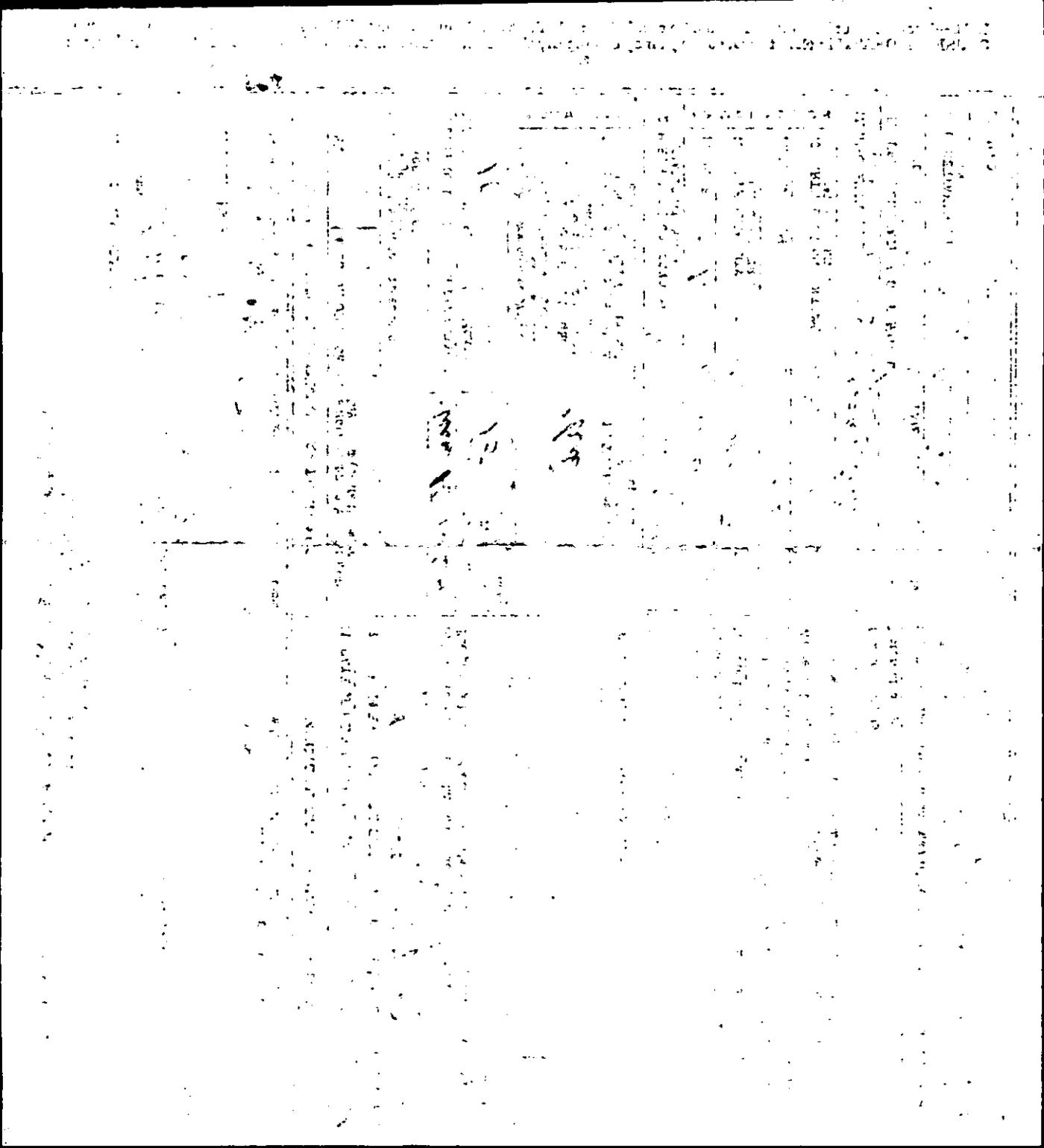
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Harry T. Berger M. D.
 (Address) 1306 Professional Bldg.

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.

AUG 21 1934



1 Kansas City

WASHINGTON

24879

3477

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Nancy La Bella*
Who died at _____ on *July 25 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *10* Months _____ Days *15*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: *ae Internal hydrocephalus* Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician *Dr. H.C. Berger*
Address of physician *1306 Prof. Bldg.*

Signature of Registrar *M. M. Carbow* Date filed *7/27/34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No:
Primary Reg. Dist. No:

E. T. McLaugh
State Registrar

Special Agent.

Now tuberculous - Acquired - ae. Internal hydrocephalus

S-24879