

FEB 20 1936

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

Do not use this space

1390

1. PLACE OF DEATH

County Jackson
Township Kaw
City Keosauqua (No. 399)

Registration District No. 399
Primary Registration District No. 1002

File No. 243
Registered No. 243
St. Ward

2. FULL NAME

James Roncelli
(a) Residence, No. Springton, Mo. 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 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 27-1936

7. AGE YEARS 0 MONTHS 3 DAYS 24 If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None
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) Springton, Mo.

MOTHER 13. NAME Marico Roncelli

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springton, Mo.

15. MAIDEN NAME Alma Anderson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springton, Mo.

17. INFORMANT (ADDRESS) Magis Roncelli

18. BURIAL, CREMATION, OR REMOVAL PLACE Springton, Mo. DATE Jan 16 1936

19. UNDERTAKER (ADDRESS) Winkler

20. FILE NO. Jan 15 1936 M. Corone Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1936

22. I HEREBY CERTIFY That I attended deceased from Jan 7 1936 to Jan 15 1936
That saw him alive on Jan 15 1936 Death is said to have occurred on the date stated above, at 10:30 p.m.
The principal cause of death and related causes of importance were as follows:

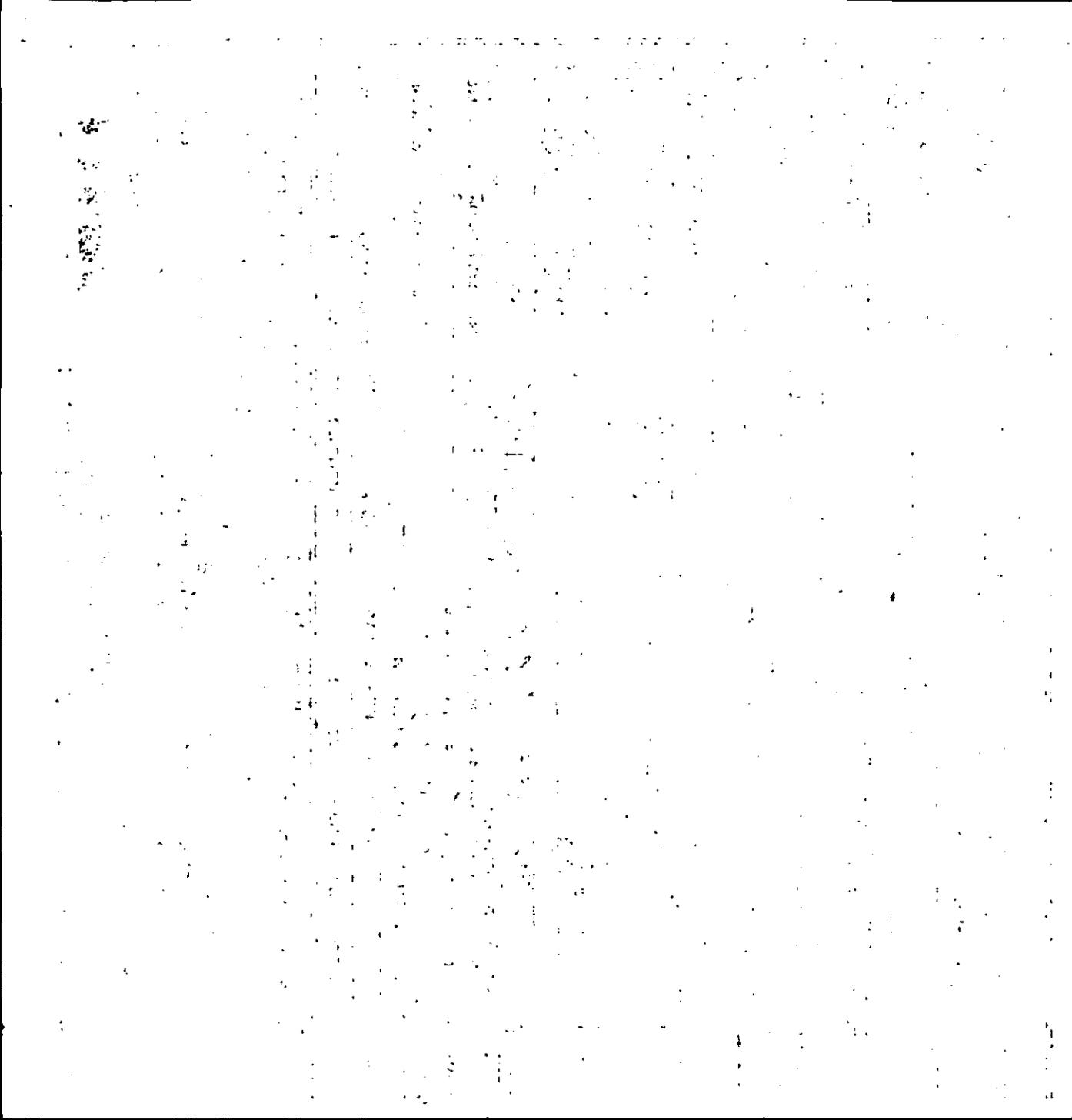
Prematurity
15
Other contributory causes of importance: Suppurative Lung Infection
Date of onset 7-27-36

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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 E. Corone, M. D.
(Address) 806 Prof Bldg, KC Mo



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1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kansas City Primary Registration District No. 1002 Registered No. 243
 City St. Louis No. 1002 Mercy Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1 Lexington, Mo. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) L

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	0	3	18	

OCCUPATION

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. _____

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) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 7-15-36 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1936

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Prematurity

Date of onset 9-27-35

Other contributory causes of importance: Upper Resp. Infection
1. Acute Infectious Enteritis
2. No Congenital Defects

1-6-36

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____
 (Signed) Harvey G. Earn
 (Address) 806 Professional Bldg

S-1390