

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

38169  
Do not use this space.

DEC 14 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kan Primary Registration District No. 602 Registered No. 4403

(c) City Kansas City (d) Street No. Childrens Mercy Hospital St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Azzaro, Michael John

(a) Residence, No. 260 28 500 Bellfontaine St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

**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) March 25 - 1938

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>7</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as 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) Kansas City, Mo

FATHER

13. NAME John Azzaro

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

MOTHER

15. MAIDEN NAME Rainie Scardino

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

17. INFORMANT (ADDRESS) John Azzaro 500 Bellfontaine

18. BURIAL, CREMATION, OR REMOVAL PLACE at Mary DATE Nov 12 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. A. Sabetti 901 E 5th

20. FILED Nov 12, 1938 M. M. Brown Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 11, 1938

22. I HEREBY CERTIFY, That I attended deceased from November 10, 1938, to November 11, 1938

I last saw him alive on November 11, 1938 Death is said to have occurred on the date stated above, at 5:20 A.M.

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

Intercerebral

Date of onset 11-9-38

Other contributory causes of importance:

Name of operation Enterostomy Date of 11-11-38

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No 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) J. A. Wilkinson, M. D.

(Address) 1103 Grand Ave.

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**