

DEPARTMENT OF HEALTH
BUREAU OF THE REGISTERS
NOV 22 1939
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36306

Registration District No. 400 Primary Registration District No. 5557 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson Benton
(b) City or town 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
71st & James A. Reed Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 Years years, months or days)

3. (a) PRINT FULL NAME Mrs Mary CAMARATA. 563

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lorenzo Camarata 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 12th 1867
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>72</u>	<u>7</u>	<u>19</u>	hr. _____ min.

9. Birthplace Italy
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Dominick Fiore

13. Birthplace Italy
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Peter Maseal

(b) Address 311 Clinton Place

17. (a) Burial (b) Date thereof 11/3/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marvs

18. (a) Signature of funeral director Melody-McGilley.

(b) Address K. C. Mo.

19. (a) 11-2-39 (b) W. M. Mearns 3105
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 71st James A. Reed Rd.
(If rural, give location)
(e) If foreign born, how long in U. S. A. 52 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1st year 1939 hour 10:30 minute AM M.

21. I hereby certify that I attended the deceased from Nov 1, 1939 to Nov 1, 1939; that I last saw her alive on Nov 1, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 30 min.

Due to _____

Due to 948

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address [Signature] Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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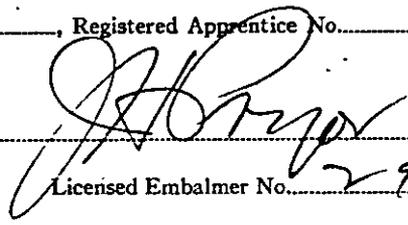
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STATEMENT BY LICENSED EMBALMER

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. 2999

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.