DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 11 1939

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 38711

Registrar's No. 4475

1. PLACE OF DEATH:

(a) County Jackson 2

(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1100 Pacific St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether

In this community —link
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo (b) County Jackson

(c) City or town Kansas
(If outside city or town limits, write "RURAL")

(d) Street No. 1100 Pacific St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Angelina Strada 363

3. (b) If veteran, name war — no

3. (c) Social Security No. — no

4. Sex Female

5. Color or race Italain

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sam Strada

6. (c) Age of husband or wife if alive abt 60 years

7. Birth date of deceased Nov. (Month) 20 (Day) 1885 (Year)

8. AGE: Years 54 | Months — | Days 3 | If less than one day — hr. ____ min.

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

10. Usual occupation House wife 7

11. Industry or business —

FATHER
12. Name Ross Vivona 7
13. Birthplace Italy (City, town, or county) 7 (State or foreign country)

MOTHER
14. Maiden name Catherina Shortino
15. Birthplace Italy (City, town, or county) ____ (State or foreign country)

16. (a) Informant's own signature Chas Arnone
(b) Address 3505 Olive st

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 25-39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt St. Mary Cemetery

18. (a) Signature of funeral director Passantino Bros
(b) Address K. C. Mo

19. (a) Nov 24 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 23 day —
year 1939 hour 6 minute 15 A M.

21. I hereby certify that I attended the deceased from Nov 22 (9 P.M.) ____, 1939, to Nov 23 (6 A.M.), 1939; that I last saw her alive on Nov 23 (1 A.M.), 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	11 hours
Due to Auricular fibrillation	—
Due to	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy none	

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

23. Signature Anthony Saladino (M. D. or other)
Address 721 Rialto Date signed Nov 24 39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 1 X19511

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 Park Rowe, Registered Apprentice No. _____ working under my personal supervision.

Signed Park Rowe

Licensed Embalmer No. 2347

P. O. Address 341 Indian Ave

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.