

FILED MAR 11 1940

Registration District No. 399

Primary Registration District No. 1002

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.

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:  
1317 East 9th 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 45 Years  
years, months or days

**3. (a) PRINT FULL NAME** Giuseppe Genova

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Vita Genova

6. (c) Age of husband or wife if alive About 80 years

7. Birth date of deceased March 8th 1856  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>83</u>	<u>II</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Produce Dealer

11. Industry or business General Produce Buis.

**MOTHER FATHER**

12. Name Salvatore Genova.

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

14. Maiden name Benedetta Gennelli

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

16. (a) Informant's own signature Mrs. P.A. Lo Sealzo

(b) Address 5149 Brookwood Rd

17. (a) Burial (b) Date thereof 2/13/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys Cemetery

18. (a) Signature of funeral director A. Albright

(b) Address 901 East 5th St.

19. (a) Feb. 12, 1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

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

(d) Street No. 1317 East 9th St  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 45 Yrs. years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 10 year 1940 hour 8 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb. 8 1940 to Feb. 10 1940 that I last saw him alive on 9 A.M. Feb 10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia

Due to Acute lobar double pneumonia

Other conditions none

(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: Of operations No

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? No  
(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 Anthony Salandino (M. D. or other) \_\_\_\_\_

Address 721 Briarwood Bldg Date signed 2/12/40

**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..... *Ray E. Snow*.....

Licensed Embalmer No. *2360*.....

P. O. Address..... *901 East 5th St*.....

**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.**