

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9967
Registrar's No. 1401

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
(a) County Jackson
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3908 Maxwell
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 32 years
years, months or days

3. (a) PRINT FULL NAME John Lawrence LaGratto
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Male 5. Color or race Italian 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Goldie LaGratto 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Oct 4 1907
(Month) (Day) (Year)

8. AGE: Years 32 Months 5 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Internal Decorator

MOTHER FATHER
11. Industry or business none
12. Name Joseph LaGratto
13. Birthplace Italy
(City, town, or county) (State or foreign country)
14. Maiden name Lucretia Casanovi
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ms Betty LaGratto
(b) Address 3908 Maxwell

17. (a) Burial (b) Date thereof April 1-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Mary's

18. (a) Signature of funeral director Panantino Bros
(b) Address 15 C 2nd

19. (a) Mch 29, 1940 (b) M. M. Torome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. 3908 Maxwell
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1940 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Occlusion gibb
Due to Atherosclerosis - Coron
Due to _____

Other conditions Persistent Thyroid
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 Joseph LaGratto (M.F.D. or other) _____
Address Kan Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING
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.

50M-5-17-39
Rev. 5-17-39
U.S. GOVERNMENT PRINTING OFFICE: 1938

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 Park Rowe

Licensed Embalmer No. 2347

P. O. Address 341 Indiana

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.