

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17353**
Registrar's No. **1880**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH

(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: 709 Brooklyn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 16 yrs. years, months or days 2 1/2

8. (a) PRINT FULL NAME Dorrick Oechipinti

8. (b) If veteran, name war none 8. (c) Social Security No. 493-12-5976

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife Mary Oechipinti 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 13 1897
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>11</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Italy (City, town, or county) (State or foreign country) 7

10. Usual occupation Sabar. 7

11. Industry or business none

MOTHER FATHER { 12. Name Severio Oechipinti 7

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

14. Maiden name Fannie Vinea

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

16. (a) Informant's own signature Mary Oechipinti

(b) Address 709 Brooklyn

17. (a) Buried (b) Date thereof May 6-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt St Marys

18. (a) Signature of funeral director Parantano Bros

(b) Address K. C. Mo

19. (a) May 5, 1940 (b) M. M. Brown
(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. 709 Brooklyn (If rural, give location)
(e) If foreign born, how long in U. S. A.? 17 1/2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1940 hour 8 minute 50 P. A. M.

21. I hereby certify that I attended the deceased from Mar. 10,
1940, to May 3, 1940,
that I last saw him alive on May 3, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Empyema Duration _____

Due to M. M. C

Due to 110

Other conditions (Include pregnancy within 3 months of death)

Operation March 5th, Paracen-

Major findings: tests Thoracis

Of operations _____

Of autopsy HO

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) Means of injury _____

23. Signature M. M. Brown, M.D. (M. D. or other) _____

Address 210 Magyle Bldg Date signed 5/4

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

Park Row

Licensed Embalmer No. 2347

P. O. Address 341 Inglewood 1507

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.