

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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: St Marys Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
(Specify whether)  
 In this community 45 Yrs  
years, months or days

3. (a) PRINT FULL NAME Antonina Enna 500  
 3. (b) If veteran, name war No 3. (c) Social Security No. 910

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Frank Enna 6. (c) Age of husband or wife if alive Wife years  
 7. Birth date of deceased May 2, 1885  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>		<u>12</u>	hr. _____ min.

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

10. Usual occupation Housewife 7

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph Damiano 7  
 13. Birthplace \_\_\_\_\_ Italy 7  
(City, town, or county) (State or foreign country)  
 14. Maiden name Anna Verdi  
 15. Birthplace \_\_\_\_\_ Italy  
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Enna  
 (b) Address Norwich Conn

17. (a) Burial (b) Date thereof 5/17/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt St Mary's Cem

18. (a) Signature of funeral director A. White  
 (b) Address 901 E 5th

19. (a) May 16, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limit, write "RURAL")  
 (d) Street No. 1131 Mo Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 45 years years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month May day 14  
 year 1940 hour 8 minute 05 P.M.

21. I hereby certify that I attended the deceased from Apr 1, 1940, to May 14, 1940, that I last saw her alive on May 14, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Urinary Suppression 48 hrs

Due to Hypertensive Cardiovascular-Renal disease 5 yrs

Due to \_\_\_\_\_ 131

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations none  
 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? \_\_\_\_\_

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

23. Signature Louis Scarpellino (M. D. or other) \_\_\_\_\_  
 Address 822 Argyle Bldg Date signed May 16-40

**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. Linn*

Licensed Embalmer No. 2560

P. O. Address

961 East 6th

**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.**