

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

Rev. 5-17-39 I 119511

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20958**
Registrar's No. **2575**

Registration District No. **399**

Primary Registration District No. **1002**

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 Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo - 15 days
(Specify whether
In this community 1 mo 15 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 521 Cherry
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Infant Bono 5 MD

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 9th 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>1</u>	<u>15</u>	_____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Bono

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

14. Maiden name Grace Scemega

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

16. (a) Informant's own signature Joseph Bono

(b) Address 521 Cherry

17. (a) Burial (b) Date thereof June 25th 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director John J. Scemega

(b) Address 537 Campbell St

19. (a) June 25, 1940 (b) M. M. Groves
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th
year 1940 hour Nine minute Ten P.M.

21. I hereby certify that I attended the deceased from May 9 - 1940
to June 24 - 1940

that I last saw him alive on June 24 - 40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurely 159

Due to _____
Due to _____

Other conditions (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 Louis Scarpellino (M. D. or other) md
Address 537 Campbell St Date signed 6/25/40

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.