

140
139
3159

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
 (a) County Kansas
 (b) City or town _____
 (c) Name of hospital or institution: St. Maris Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 30 yrs years, months or days

3. (a) PRINT FULL NAME Joseph Lorea
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 60

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife: Margaretta Lorea 6. (c) Age of husband or wife if alive 42 years
 7. Birth date of deceased Oct. 25 1903 (Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 21 If less than one day hr. _____ min. _____

9. Birthplace New Orleans La. (City, town, or county) (State or foreign country)

10. Usual occupation Saloon keeper

11. Industry or business _____

12. Name Anthony Lorea
 13. Birthplace Italy (City, town, or county) (State or foreign country)

14. Maiden name Rose Terranello
 15. Birthplace Italy (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Chas. Pasantino
 (b) Address 2117 Grand Blvd KCMO

17. (a) Interred (b) Date thereof Aug 19-40 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Maris

18. (a) Signature of funeral director Pasantino Bros
 (b) Address KCMO

19. (a) Aug. 17, 1940 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas (If outside city or town limits, write "RURAL")
 (d) Street No. 2804 E 9th St (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16 year 1940 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Aug 12th 1940 to Aug 16 1940 that I last saw him alive on Aug. 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronch pneumonia Duration 4 days

Due to DDV
 Due to _____

Other conditions Cardiac failure (Include pregnancy within 3 months of death) Duration 2 days

Major findings: Of operations _____
 Of autopsy _____
 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 Scapellato M. D. or other _____
 Address 822 Argyle Date signed 8/16/40

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

MOTHER FATHER

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..... *Frank Rowe*

Licensed Embalmer No. *2347*

P. O. Address *Remo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27622
Registrar's No. 3256

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: St. Marys
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Joseph Lorea

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 8/17/40

19. (a) _____ (b) M. M. Browne (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. 2804 1/2 69th
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH month Aug day 16
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Broncho Pneumonia

Due to _____ 107a
Due to _____

Other conditions Cardiac Failure
(Include pregnancy within 3 months of death)

Major findings Tuberculous Myocarditis
Of operations _____

Of autopsy _____

Duration
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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-27622