

RECEIVED SEP 5 1940 599

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27654

1002

Registrar's No. 3288

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Menorah 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 _____
years, months or days)

3. (a) PRINT FULL NAME Infant Blando 453

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 Single

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

7. Birth date of deceased Aug 20 1940
(Month) (Day) (Year)

8. AGE: Years -- Months -- Days -- If less than one day 8 1/2 hr. _____ min.

9. Birthplace Kansas City Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Blando

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

14. Maiden name Carmin Ottoviano

15. Birthplace Kansas City Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Blando

(b) Address 5831 Swope Park Way

17. (a) Burial (b) Date thereof Aug 20/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director A. Sebbeto

(b) Address 901 East 5th Street

19. (a) Aug. 20, 1940 (b) Mo Mo Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5831 Swope Parkway
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20th
year 1940 hour 4 minute 10 a. M.

21. I hereby certify that I attended the deceased from 12th 9 m.
Aug 20, 1940, to _____, 1940

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to prematurity

Due to 159

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 _____ (M. D. or other) _____

Address 909 p. 1st St. Bldg Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Roy E. Snow
Licensed Embalmer No. 2560
P. O. Address 1807 E. 29th St

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.