

S. No. 2
4-13-40
7-5-17-39
I X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28009
Registrar's No. 913

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs. 15 days
In this community 3 yrs 15 da
years, months or days (Specify whether)

3. (a) PRINT FULL NAME FRANK MANGIARCINA
(b) If veteran, name war None
(c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Mrs.
(c) Age of husband or wife if alive 47 years
7. Birth date of deceased December 24, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 years 7 25 hr. min.

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

10. Usual occupation Saloon Keeper

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace ?
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records

(b) Address

17. (a) Removal (b) Date thereof 8/19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director M.C. ...

(b) Address M.C. ...

19. (a) 8/19-1940 (b) P.S. Tate
(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 limits, write "RURAL")
(d) Street No. 1418 Independence
(If rural, give location)
(e) If foreign born, how long in U. S. A. Unknown years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1940 hour 12:15 minute P.M.

21. I hereby certify that I attended the deceased from Entered this in
attestation 8-4, 1937, to 8-18, 1940
that I last saw him alive on 8-18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
As determined by X-ray
Due to J.P.

Other conditions Manic Depression Psychosis
(Include pregnancy within 3 months of death)
Depressed type

Major findings:
Of operations
Of autopsy none

Duration
June 1-40
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?
85

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

23. Signature P.S. Tate (M. D. or other) MD.
Address State Hosp #2 - St Joseph Date signed 8-19-40

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 Park
A. Rowe Registered Apprentice No. 2347
working under my personal supervision.

Signed Park A. Rowe,

Licensed Embalmer No. 2347

P. O. Address 349 Indian M.C.

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, fact should be so stated above.