

No. 2
1-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1002

State File No. **41233**
4626
Registrar's No.

ED JAN 8 1941 399
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Westly Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 39 Years (Specify whether 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. 2835 Wabash
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 39 Years years.

8. (a) PRINT FULL NAME John Victor Sprofera

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

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

6. (b) Name of husband or wife Gladys Srofera 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Dec. 25-1900
(Month) (Day) (Year)

8. AGE: Years 39 Months II Days 7-23 If less than one day hr. min.

9. Birthplace St. James LA.
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

MOTHER FATHER { 12. Name Cascimo Srofera 7
13. Birthplace Italy 7
(City, town, or county) (State or foreign country)
14. Maiden name Anna Pernicero
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Gladys Sprofera
(b) Address 2835 Wabash

17. (a) Burial (b) Date thereat Dec. 5 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Mary's

18. (a) Signature of funeral director Passantino Bro's.
(b) Address Kansas City Mo.

19. (a) 12-4-40 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2
year 1940 hour II minute 30 M.

21. I hereby certify that I attended the deceased from Nov. 22
1940 to Dec 2 19 40
that I last saw him alive on Dec 2 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Parenchymatous diffuse
Due to cholel cystitis & gangrenous gall bladder
Due to 129

Other conditions (Include pregnancy within 3 months of death)
Major findings: cholel cystitis
-Of operations
Of autopsy no

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) no
(b) Date of occurrence no
(c) Where did injury occur? no
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature J. F. Mackey (M. D. or other)
Address _____ Date signed 12-3-40

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 Park G. Rowe.....

Licensed Embalmer No. 2347.....

P.O. Address Kansas City Mo......

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.