

No. 2
4-41
17-39
K26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **13523**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1504**

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:
Resarch 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 **38 Years** (Specify whether
years, months or days)

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. **534 Campbell St.**
(If rural, give location)
(e) Citizen of foreign country? **38** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Marco (Mike) Ardagna**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mrs Tina Ardagna** 6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **May 26 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **ID** Days **18** If less than one day hr. min.

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

10. Usual occupation **Labor**

11. Industry or business _____
12. Name **Iznasio Ardagna**
13. Birthplace **Italy** (City, town, or county) (State or foreign country) **5**
14. Maiden name **Do not know**
15. Birthplace **Italy** (City, town, or county) (State or foreign country) **5**

16. (a) Informant **Ned Ardagna**
(b) Address **534 Campbell St.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **April 17 1941** (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. St. Marys.**

18. (a) Signature of funeral director **Passantino Bro's.**
(b) Address **K. G. Mo.**

19. (a) **Apr. 16 1941** (Date received local registrar) (b) **m. m. Crowe** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14** year **1941** hour **6** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **April 9** 1941 to **April 14** 1941, and that death occurred on the date and hour stated above.

Immediate cause of death **Toxemia** Duration **5 days**

Due to **Arterial hypertension**

Due to **Hypostatic Pneumonia** 5 days

Other conditions (Include pregnancy within 3 months of death)

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?

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

23. Signature **S. Saladino** (M. D. or other) Address **721 Riatts bldg** Date signed **4/15/41**

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

MOTHER FATHER

111 B

STATE OF MISSISSIPPI

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 N. C. 200

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1504

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: Research Hospital
(d) Length of stay: In hospital or institution _____
In this community _____

3. (a) PRINT FULL NAME: Marcos (Mike) Cardenas
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: Male 5. Color or race: White 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 56 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 4/16/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month April day 14th year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that he/she was h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Ebtema
Due to: Arterial hyper-tension 5 day
Due to: Hypostatic pneumonia 5 day
Ebtema of the lungs
Other conditions: _____
Major findings: 12+ 1316
Of operations: _____

Arteriosclerosis nephritis, atherosclerosis of aorta and coronaries, cholelithiasis, cholecystitis, chr. appendicitis
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: a. Salactium (M. D. or other) _____
Address: 721 Nualts Date signed: 5/21/41

SUPPLEMENTARY

S-13528