

Registration District No. 399 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution St. Mary's Hosp.
(d) Length of stay: In hospital or institution 34 yrs
In this community 34 yrs years, months or days

3. (a) PRINT FULL NAME LENA FERRARA
3. (b) If veteran, name war —
3. (c) Social Security No. No

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Feb 17 1895 (Month) (Day) (Year)

8. AGE: Years 46 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Ralph Santoro

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

14. Maiden name Rose Delpercio

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

16. (a) Informant Vincenzo Ferrara

(b) Address 541 Tracy

17. (a) Burial (b) Date thereof 5/15/41
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director ICM

(b) Address 1420 Proj. Bldg

19. (a) May 14 - 41 (b) M. M. Craive
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(d) Street No. 541 Tracy
(e) If foreign born, how long in U. S. A.? 34 yrs years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 12
year 1941 hour — minute 9 A.M.

21. I hereby certify that I attended the deceased from Sub 20
1941 to May 12 1941
that I last saw her alive on May 12 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiac-vascular disease

Due to —
Due to —

Other conditions Hypertensive pneumonia
(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:
(e) 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? —

23. Signature — (Specify type of physician)
While at work? — (e) Means of injury —
Address 1420 Proj. Bldg Date signed 5/14

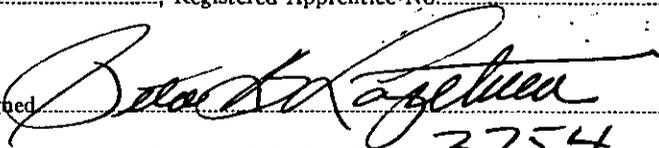
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No.

3754

P. O. Address.....

KC 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, fact should be so stated above.