

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas
(c) Name of hospital or institution:
551 Tracy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 yrs
In this community 30 yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME GIOVANNINA BEGULIA

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Salvatore 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 50 Months - Days - If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Tony Higha

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

14. Maiden name Giovanna Della

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

16. (a) Informant Salvatore Begulia

(b) Address 570 Tracy

17. (a) Burial (b) Date thereof 12/27/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys Cem

18. (a) Signature of funeral director Sebbity D. Carralla

(b) Address 901 E 5th

19. (a) 12-26-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas 048
(If outside city or town limits, write "RURAL")
(d) Street No. 570 Tracy 073
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23 1941
year hour minute

21. I hereby certify that attended deceased from 7:35 P 1941
that last saw him alive on 12/23/41 at 7:35 P
and death occurred on the date and hour stated above.
Immediate cause of death Hypertrophy of the heart
Intercurrent myocardial fibrosis

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 95C²

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?

While at work (Specify type of place) (Specify type of injury)
23. Signature Walter A. ... (M. D. or other) 3
Address W. C. Mo. Date signed

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

MOTHER FATHER

48
89
3

AUG 26 1948

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.....

Ray E Snow

Licensed Embalmer No.....

2560

P. O. Address.....

901 E 5th

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.