

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 19 1942

Registration District No. 449

Primary Registration District No. 1002

Registrar's No. 4046

1. PLACE OF DEATH: Jackson

(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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)

In this community 7 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town KANSAS
(If outside city or town limits, write "RURAL")

(d) Street No. 329 Olive St
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Salvatore Engrashotta

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 1 year 1942 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from Oct 5, 1942 to Nov 2, 1942

that I last saw him alive on Nov 1, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Perforation of stomach

Due to: Post operative perforated gastritis

Due to: 46 B

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 6 of stomach

Of operations _____

Of autopsy _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased NOV 18 1884
(Month) (Day) (Year)

8. AGE: Years 57 Months 11 Days 18 If less than one day hr. _____ min. _____

9. Birthplace Italy 5
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business none

MOTHER FATHER

12. Name John Engrashotta

13. Birthplace Italy 5
(City, town, or county) (State or foreign country)

14. Maiden name Bredigotta

15. Birthplace Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant John (Engle) Engrashotta

(b) Address 329 Olive St

17. (a) Burial (b) Date thereof Nov 3 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Passarino Bras

(b) Address 14 C.M.O.

19. (a) 11-2-42 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

Duration _____

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) (e) Means of injury 0

23. Signature Sean J. Williams (M. D. or other) _____

Address 806 P.W. Bldg. Date signed 11/2/42

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

X

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Dr. D. Q. Williams
Prof. - Biology
11 AM '10

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. Me.

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.