S. No. 2
0M—2-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 6076

Registrar's No. 878

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph's Hosp. O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs. (Specify whether years, months or days)

In this community 4 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town K.C. (If outside city or town limits, write "RURAL") 5 8

(d) Street No. 711 E 5th (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country O

3. (a) PRINT FULL NAME Infant Gargotta

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 S O

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 20 (Day) 1944 (Year)

8. AGE: Years | Months | Days | If less than one day 4 hr. 15 min.

9. Birthplace K.C. (City, town, or county) Mo. O (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Anthony Gargotta
13. Birthplace K.C. Mo. O (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Josephine Del Percio
15. Birthplace K.C. Mo. O (City, town, or county) (State or foreign country)

16. (a) Informant Anthony Gargotta

(b) Address 711 E 5th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/44 (Month) (Day) (Year)

(c) Place: burial or cremation Mt St Marys

18. (a) Signature of funeral director Sebbetos

(b) Address 901 E 5th

19. (a) 2-23-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20th year 1944 hour 10 30 minute 30 A.M.

21. I hereby certify that I attended the deceased from birth 2-20, 1944, to 2-21, 1944 that I last saw her alive on 12 mid 2-21, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Erythroblastosis fetalis	
Due to Prematurity	7th mo.
Due to Polyhydramnios 1st Trimest	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy not permitted	

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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 O

23. Signature A B Sinclair Jr (M. D. or other) MD

Address 4711 Central Street Date signed 2-23-44

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.