

No. 2-4  
1-243  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23862**  
Registrar's No. **3103**

**FILED AUG 9 1944 49**  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
(Specify whether) \_\_\_\_\_  
In this community 35 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Jackson  
(c) City or town Kansas City MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4018 3rd ST  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Romano  
(b) If veteran, name war NO  
(c) Social Security No. 495-07-8268

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Sadie Romano  
(c) Age of husband or wife if alive 35 years  
7. Birth date of deceased Aug 15 1903  
(Month) (Day) (Year)

8. AGE: Years 40 Months 11 Days 12  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation clean

11. Industry or business \_\_\_\_\_

12. Name Tony Romano

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

14. Maiden name Elizabetta di P...

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

16. (a) Informant Sadie Romano

(b) Address 4018 3rd ST

17. (a) Burial (b) Date thereof 7/29/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT ST MARYS

18. (a) Signature of funeral director Pimentel Bros.  
(b) Address Kansas City MO

19. (a) 7-28-44 (b) H. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27  
year 1944 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 29, 1944, to July 27, 1944;  
that I last saw h. alive on July 27, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death glomerular nephritis Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Hypertension Cirrhosis  
(Include pregnancy within 6 months of death) heart failure

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J. C. Romano (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 7/28/44

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

MOTHER FATHER

JUN 29 1953

---

---

**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..... *Pauls M. Rowe* .....

Licensed Embalmer No. *2347*

P. O. Address..... *19 James City 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.**

Registration District No. 149 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  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME James Romano  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug 15 (Month) (Day) (Year)

8. AGE: Years 40 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 \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

**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. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_  
 Duration \_\_\_\_\_

Due to acute cerebral nephritis  
 Due to \_\_\_\_\_ 130

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy n.m.o.

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? \_\_\_\_\_

23. Signature \_\_\_\_\_ (Specify type of place) (c) Means of injury  
 While at work? \_\_\_\_\_ (M. D. or other)  
 Date signed \_\_\_\_\_

SUPPLEMENTARY

23862