

FILED NOV 20 1944

Registration District No. 149

Primary Registration District No. 10.02

Registrar's No. 4461

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
320 Wabash
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community 48 yrs
years, months or days)

3. (a) PRINT FULL NAME CLARA CARULLO

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased May 28 1896
(Month) (Day) (Year)

8. AGE: Years 48 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name Antio Russo

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

14. Maiden name Filomena ?

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

16. (a) Informant Fate Carully

(b) Address 320 Wabash

17. (a) Burial (b) Date thereof 11/8/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int St Marys Cem

18. (a) Signature of funeral director Sebbeto's

(b) Address 901 E 5th

19. (a) 11-6-44 (b) D.E. Brown
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town K.C.
(If outside city or town limits, write "RURAL")
(d) Street No. 320 Wabash
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 15
year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-5 1944 to 11-5 1944

that I last saw him alive on 11-5 1944 and that death occurred on the date and hour stated above

Immediate cause of death myocarditis Duration

Due to myofertension

Due to 61

Other conditions breathre mellitus
(Include pregnancy within 3 months of death)

Major findings: Obesity

Of operations

Of autopsy none

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

23. Signature H. H. Russo (M. D. or other) M.D.

Address 1024 Rialto Bldg Date signed 11-6-44

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

MOTHER FATHER

1024
Health Bldg
St. Louis

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. ~~2560~~
working under my personal supervision.

Signed Ray E Snow
Licensed Embalmer No. 2560
P. O. Address K 6 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.