

FILED AUG 27 1945

Registration District No. **27** Primary Registration District No. **1002** Registrar's No. **3340**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **General Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6-28-45-8-7-45**
 (Specify whether years, months or days) **25 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **632 Virginia**
 (If rural, give location)
 (e) Citizen of foreign country? **No**
 If yes, name country _____

3. (a) PRINT FULL NAME **Tony Sirna**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **494-12-1615**

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sadene Strano**
6. (c) Age of husband or wife if alive **21** years
7. Birth date of deceased **Nov 1818**
 (Month) (Day) (Year)

8. AGE: Years **26** Months **9** Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation **Saloon**

11. Industry or business _____

12. Name **Vito Sirna**

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

14. Maiden name **Mrs. Madonna**

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

16. (a) Informant **Ross Frizzell**

(b) Address **319 Olive St**

17. (a) Burial, cremation, or removal **Burial** (b) Date thereof **Aug 10 45**
 (Month) (Day) (Year)

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

18. (a) Signature of funeral director **J. J. ...**

(b) Address **12 Cmo**

19. (a) 8-8-45 (Date received local registrar) (b) **Geraldine Holmes** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **7** year **1945** hour **11** minute **45** A. M.

21. I hereby certify that I attended the deceased from **June 28**, 19**45** to **August 7**, 19**45**;
 that I last saw him alive on **August 7**, 19**45**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac decompensation due to congenital heart disease bronchopneumonia**
 Due to _____

Due to _____

Other conditions **157e**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy **see above**

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) **Med. Dir. K.C. General Hospital** (Cause of injury)

23. Signature **Clark W. Sealy** (Physician)
Med. Dir. K.C. General Hospital (Physician)

Address _____

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Francis Walton
Licensed Embalmer No. 2744
P. O. Address KCMO

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.