

No. 2
1045
17-30
47970

FILED APR 24 1947

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 111

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 90 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Joseph TRANSANO

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M Color or race W

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

6. (b) Name of husband or wife Minnie TRANSANO

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

7. Birth date of deceased Mar 19 1863
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1947 hour 9 minute 55 AM

21. I hereby certify that I attended the deceased from March 19
1947 to April 18 1947;
that I last saw him alive on April 18 1947;
and that death occurred on the date and hour stated above.

8. AGE: Years 84 Months 0 Days 27
If less than one day hr. min.

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

Immediate cause of death Shock Duration 2 hrs

Due to fall 2 hrs

Due to Cerebral hemorrhage 2 hrs

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant John B. Transano
(b) Address Novinger Mo

17. (a) Burial (b) Date thereof Apr 21-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger Mo

18. (a) Signature of funeral director Paul E. Gupper
(b) Address Novinger Mo

19. (a) 4-18-47 (b) Kate Samant
(Date received local registrar) (Registrar's signature)

Major findings: 18.6.47

Of operations 18

Of autopsy 18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 1

(b) Date of occurrence

(c) Where did injury occur? Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 2

While at work? (Specify type of place)

(e) Means of injury

23. Signature M. T. Hutcheson or other DO
Address Firksville, Mo. Date signed 4-18-47

RECEIVED
District Health Officer No. 10
District File Number 447204
Date Filed APR 22 1947

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 Louis E. Hopper
Licensed Embalmer No. 426
P. O. Address Clarence M.

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. 1

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Joseph Trausena

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 wid

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

7. Birth date of deceased March 19 1986
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____ (b) County _____
(c) City or town _____
(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 April 1987 year, 2 hour, 48 minute M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 4-18-87

(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?

Community Nursing Home
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M.T. Lettich (M. D. or other) DO

Address _____ Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

12327