

S. No. 2  
OM-5-43  
v. 5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21182  
2783  
Registrar's No.

FILED JUL 14 1947  
1949

Registration District No. \_\_\_\_\_ 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 K. C.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Menorah Hosp. 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 week  
 In this community 24 yrs.  
 years, months or days (Specify whether)

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. 2807 E 9th  
 (If rural, give location)  
 (e) Citizen of foreign country? Yes (Yes or No)  
 If yes, name country Ireland

3. (a) PRINT FULL NAME BALDASSERO (BENNIE) SCIORTINO

3. (b) If veteran, name war NO 3. (c) Social Security No. 702-14-5998

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

6. (b) Name of husband or wife Antonina 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Nov 1 1881  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>7</u>	<u>27</u>	hr. min.

9. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

10. Usual occupation R. R. Laborer

11. Industry or business

12. Name Emanuel Sciortino

13. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Nicusa

15. Birthplace Italy 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Fair Angelone  
(b) Address 111 N. Topping

17. (a) Burial (b) Date thereof 7/11/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt St Marys

18. (a) Signature of funeral director Sebbeto's  
(b) Address City  
19. (a) 6-30-47 (b) Aldredine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28  
year 1947 hour 7:30 PM minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from June 20  
1947 to June 28 1947  
that I last saw him alive on June 28 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary occlusion 8 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Generalized arteriosclerosis years  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy yes 94%  
 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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature John L. Lapp (M. D. or other) Ind.  
Address 131 W. Professional Bldg Date signed 6/29/47

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.....

*Roy E Snow*

Licensed Embalmer No. 2540

P. O. Address R E 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.**