

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

APR 29 1934

791  
1003

14403

**1. PLACE OF DEATH**

County.....*Mo. Baptist Hosp* Registration District No.....  
 Township.....*St. Louis mo* Primary Registration District No.....  
 City.....*St. Louis mo* (No. ....) St. .... Ward)

File No.....  
 Registered No.....*3232*  
 St. .... Ward)

**2. FULL NAME**

(a) Residence, No. *1228* *1228 No. 7 St.* St. *25* Ward.  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *27* yrs. mos. ds. How long in U. S., if of foreign birth? *27* yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>M.</i>	4. COLOR OR RACE <i>W.</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Tina Favazza</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>March 14 1889</i>		
7. AGE	YEARS <i>46</i>	MONTHS <i>1</i>
	DAY <i>0</i>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc..... <i>Fruit Business</i>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Terrasine Italy</i>		
FATHER	13. NAME <i>Francesco Paolo Favazza</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Terrasine Italy</i>	
MOTHER	15. MAIDEN NAME <i>Lisa Tocco</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Terrasine Italy</i>	
17. INFORMANT (ADDRESS) <i>Tina Favazza 1228 No. 7 St.</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Calvary Cem</i> DATE <i>April 10 1935</i>		
19. UNDERTAKER (ADDRESS) <i>Pasquale Miceli 1133 One Kings Highway</i>		
20. FILED <i>HPR - 8 10 34</i> 19..... Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 7 1934*

22. I HEREBY CERTIFY, That I attended deceased from *March 1934* to *April 7 1934*  
 I last saw him alive on *April 7 1934* Death is said to have occurred on the date stated above, at *6:30 p.m.*  
 The principal cause of death and related causes of importance were as follows:  
*Tubercular Meningitis* Date of onset *12-25-33*  
*24*  
 Other contributory causes of importance:  
*Chronic Bronchitis*  
*asthma*

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no*  
 If so, specify *no*  
 (Signed) *Ronald G. Suple* M. D.  
 (Address) *705 - Olive St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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