

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.

107, *Garrison*
 12 1939
 9. 6619

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

8444
 Do not use this space.

1. PLACE OF DEATH
 (a) County..... 1 Registration District No..... 791
 (b) Township..... Primary Registration District No..... 1003
 (c) City..... *St. Louis* (d) Street No..... *St. Anthony Hospital* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *LAWRENCE-FERRARIS*
 (a) Residence, No. *3914 Lafayette ave* St. *17* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF *Florence Ferraris* (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 4 1876*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 10 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Shoe Worker*

9. Industry or business in which work was done, as saw mill, bank, etc.

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) *Ill*

FATHER
 13. NAME *Vincent Ferraris*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Italy*

MOTHER
 15. MAIDEN NAME *Mathilda Kominhel*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Switzerland*

17. INFORMANT (ADDRESS) *Mrs. Florence Ferraris 3914 Lafayette ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Anthony's* DATE *March 9 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Edw. St. Howard 4212 St. Louis ave*

20. FILED BY *J. D. Brediak* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 6 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 28 1939* to *March 6 1939*
 I last saw him alive on *March 6 1939*. Death is said to have occurred on the date stated above, at *9 P. M.*
 The principal cause of death and related causes of importance were as follows:
Lobar pneumonia Date of onset *2-28-39*

Other contributory causes of importance: *100*

Name of operation *none* Date of.....
 What test confirmed diagnosis? *X-ray Phys* Was there an autopsy? *Yes*

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.....
 (Signed) *Edmund R. Sheridan M. D.*
 (Address) *3903 De Rouley St.*

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.....

J. G. Sullivan

Licensed Embalmer No. *1122*

P. O. Address.....

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, above space should be left blank.