

FILED APR 21 1945

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 399

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months 14 days
(Specify whether) 37 years
In this community 37 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL") 11
(d) Street No. 708 Carley St.
(If rural, give location)
(e) Citizen of foreign country? yes? (Yes or No)
If yes, name country 7

3. (a) PRINT FULL NAME PETER FANTANZZO.

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased 7 - 7 - 1903
(Month) (Day) (Year)

8. AGE: Years 42 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Saloon Keeper

11. Industry or business Brewery

MOTHER FATHER { 12. Name John Fantanzzo
13. Birthplace unknown Italy
(City, town, or county) (Street or foreign country)
14. Maiden name Carmela Gina
15. Birthplace unknown Italy
(City, town, or county) (Street or foreign country)

16. (a) Informant Mrs. Josephine Depina
(b) Address 708 Carley St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 4-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery
18. (a) Signature of funeral director Samuel Home
(b) Address 224 10th St St. Joseph, Mo

19. (a) 4-17-45 (b) Della D. Dicks
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 12
year 1945 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from 6-10-44
8-21-44-3-9-45 to 4-12-1945
that I last saw him alive on 4-12-1945
and that death occurred on the date and hour stated above.

Immediate cause of death..... Hypostatic Pneumonia Duration 4 days.

Due to Meningo-encephalitis
Syphilis 5 years

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... 309
Of autopsy.....
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.....
Signature J. H. Morrison (M. D. or other)
Address State Hospital No. 2 Date signed 4/12/45

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

Get signed

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

Mollie E. Sidenfaden

Licensed Embalmer No.

4235

P. O. Address

St. Joseph, Mo.

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.