

Registration District No. _____

Primary Registration District No. _____

1003

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

1. PLACE OF DEATH:

(a) County no
 (b) City or town no
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1104 N. Newstead
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 00
 (c) City or town St Louis 1711
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1104 N. Newstead
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME FEDERICO SCARNA

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

4. Sex male 5. Color white 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased June 6 1888
 (Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Cologero Scarna

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

14. Maiden name Antonina Scarna

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

16. (a) Informant Mrs Rose Suggs

(b) Address 1104 N. Newstead Ave

17. (a) burial (b) Date thereof Aug 1
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Catholic Church

18. (a) Signature of funeral director Paul A. Calcutt

(b) Address 5142 S. Aggett Ave

19. (a) AUG 10 1945
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8th
 year 1945 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug 1st, 1945 to Aug 8, 1945
 that I last saw him alive on Aug 8, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Myocarditis Chronic

Due to _____

Other conditions Leg. Inguinal Hernia
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy AB

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 F. Scarna M.D.

Address 5428th Magnolia Date signed 8/10/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No. 2376

P. O. Address. 5142 Daggett

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7020

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1104 N Newstead
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Federico Scarna
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Aug 27 1945 (b) J. F. Bredech
(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 _____

20. MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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

Major findings:
Of operations _____
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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

26092