

FILED JAN 12 1946
Registration District No. 276

Primary Registration District No. 5947

Registrar's No. 15

1. PLACE OF DEATH:
 (a) County Shelby St James Twp
 (b) City or town St James Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (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) years

3. (a) PRINT FULL NAME James Filippi
 3. (b) If veteran _____ (c) Social Security name way _____ No. _____

4. Sex Male 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Filippi 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased: (Month) 2x (Day) 18 (Year) 73

8. AGE: Years 72 Months 9 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Geo Filippi

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

14. Maiden name Anna Serco

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

16. (a) Informant Frank Filippi

(b) Address St James mo

17. (a) Burial (b) Date thereof: (Month) 11 (Day) 21 (Year) 45

(c) Place: burial or cremation Marion cem

18. (a) Signature of funeral director W. Schukler

(b) Address St James mo

19. (a) 12-26-45 (b) Cora E. Birmingham (Registrar's signature)
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County 81
 (c) City or town _____ (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION 18
 20. DATE OF DEATH: Month Nov day 18 year 1945 hour 3 minute 0 M. 1100
 21. I hereby certify that I attended the deceased from Nov 1918 to Nov 1945 that I last saw him alive on Nov 18 and that death occurred on the date and hour stated above.

Immediate cause of death: Ch. Myocarditis
 Due to Cholerae typhos
 Due to Ch. Myocarditis Hepatitis
 Other conditions: _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: no
 Of autopsy: no

Duration _____
 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 E. A. Scott (M. D. or other) _____
 _____ Date signed 11-26-45

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

MOTHER FATHER

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. E. Licklider

Licensed Embalmer No. 1870

P. O. Address J. James

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.

Registration District No. 276

Primary Registration District No. 5947

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Ruide St James Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

James Felippi

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

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

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

7. Birth date of deceased Jan 24 1945
(Month) (Day) (Year)

8. AGE: Years 72 Months 24 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Italy
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 16-45 (b) Cara E. Birmingham
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps
(c) City or town Ruide
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. _____ immediate cause of death.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

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