. S. No. 2
M—1/47
ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25553

FILED AUG 8 1947 318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7113

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution newborn (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1938 Cass Ave.,
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Infant ~~BABY FIRL~~ GIARAFFA

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE

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 June (Month) 29th, (Day) 1947 (Year)

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

9. Birthplace St. Louis, City Hospital (City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business

FATHER
12. Name Angelo Giaraffa
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bernice Jones
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Bd. St. Louis

18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutgers Sa

19. (a) JUL 31 1947 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st year 1947 hour 6:25 minute P M.

21. I hereby certify that I attended the deceased from 6/29/47 19 to July 1st 1947; that I last saw er alive on July 1st 1947; and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURITY

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Edward M. Parkins 7/3/47 (M. D. or other) M D

Address 1515 Lafayette Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....

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, fact should be so stated above.