

FILED DEC 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39730**  
**04580**  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

96

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Manchester</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>85 OR TOWN Lemay</u>	
c. LENGTH OF STAY (In this place) <u>8m 12 Days</u>		d. STREET ADDRESS (If rural, give location) <u>621 Allen Ave</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Alvina</u>	b. (Middle) <u>Ardwine</u>	c. (Last) <u>Ferrara</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 2 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>? 1879</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY .....	11. BIRTHPLACE (State or foreign country) <u>Italy 5</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Unkown</u>	13b. MOTHER'S MAIDEN NAME <u>Unkown</u>	14. NAME OF HUSBAND OR WIFE <u>John Ferrara, Dec.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ross</u>	ADDRESS <u>6227 Plymouth Ave</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>senility</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4222	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Mar 22 1949 to Dec 2, 1949, that I last saw the deceased alive on Nov 28, 1949, and that death occurred at 11 A.M. from the causes and on the date stated above.

23a. SIGNATURE <u>E.L. Merklin MD</u>	(Degree or title)	23b. ADDRESS <u>3707 Pelina</u>	23c. DATE SIGNED <u>12-3-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 3 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cent</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>12-3-49</u>	REGISTRAR'S SIGNATURE <u>Herbert K. Womack MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. W. Clark</u>	ADDRESS <u>1125 Hodiament Ave</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Merklin  
3507 Potomac  
Gr 1863

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**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed..... *Elmer P. Padwell* .....

Licensed Embalmer No. *4077* .....

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.