

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38720**  
**9982**

FILED NOV 22 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Montgomery</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>3 Mo. - 15 da</b>	c. CITY OR TOWN <b>Fitchfield</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Childrens</b>		e. STREET ADDRESS (If rural, give location) <b>703 No. Locust</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Linda</b> b. (Middle) <b>Lee</b> c. (Last) <b>Ferrari</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>11-1-54</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-20-47</b>	9. AGE (In years last birthday) <b>7 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City, and State or Foreign Country) <b>Fitchfield, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>Delmo Ferrari</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ellen Gorrell</b>		14. NAME OF HUSBAND OR WIFE			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>J. D. Johnston 500 S. Kingshighway</b>			
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Astrocycoma - Brain tumor</b>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>193X</b>	
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22. I hereby certify that I attended the deceased from **7-6-** **1954**, to **11-1**, **1954**, that I last saw the deceased alive on **11-1-**, **1954**, and that death occurred at **4:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. D. Johnston M.D.</b> (Degree or title)		23b. ADDRESS <b>500 South Kingshighway</b>		23c. DATE SIGNED <b>11-1-54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11-2-54</b>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>Fitchfield, Illinois</b>	
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DATE REC'D BY LOCAL REG. <b>NOV 3 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A.H. Hoppe 4704 Washington Ave.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *John J. Harris*.....  
Licensed Embalmer No. *410*.....  
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.