

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

22340

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City..... (No. City Hospital)..... St. .... Ward.....

File No. 6529  
Registered No. 6529  
St. .... Ward.....

**2. FULL NAME** Anthony Farsce

(a) Residence. No. 431 Antelope St., 8 Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18 - 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
15 1 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Caddy  
(b) General nature of industry, business, or establishment in which employed (or employer) Country Club  
(c) Name of employer Country Club

9. BIRTHPLACE (CITY OR TOWN) Stammin Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Nuzio Farsce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Italy  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Santa Giordano

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Italy  
(STATE OR COUNTRY)

14. INFORMANT Nuzio Farsce  
(Address) #31 Antelope

15. FILED 21 1922 May C. Stark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... 4. a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Shock & Injuries (Traumatic)  
Amputation of Left Arm  
+ Leg Run over by train  
CONTRIBUTORY (SECONDARY) in City  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Accident

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

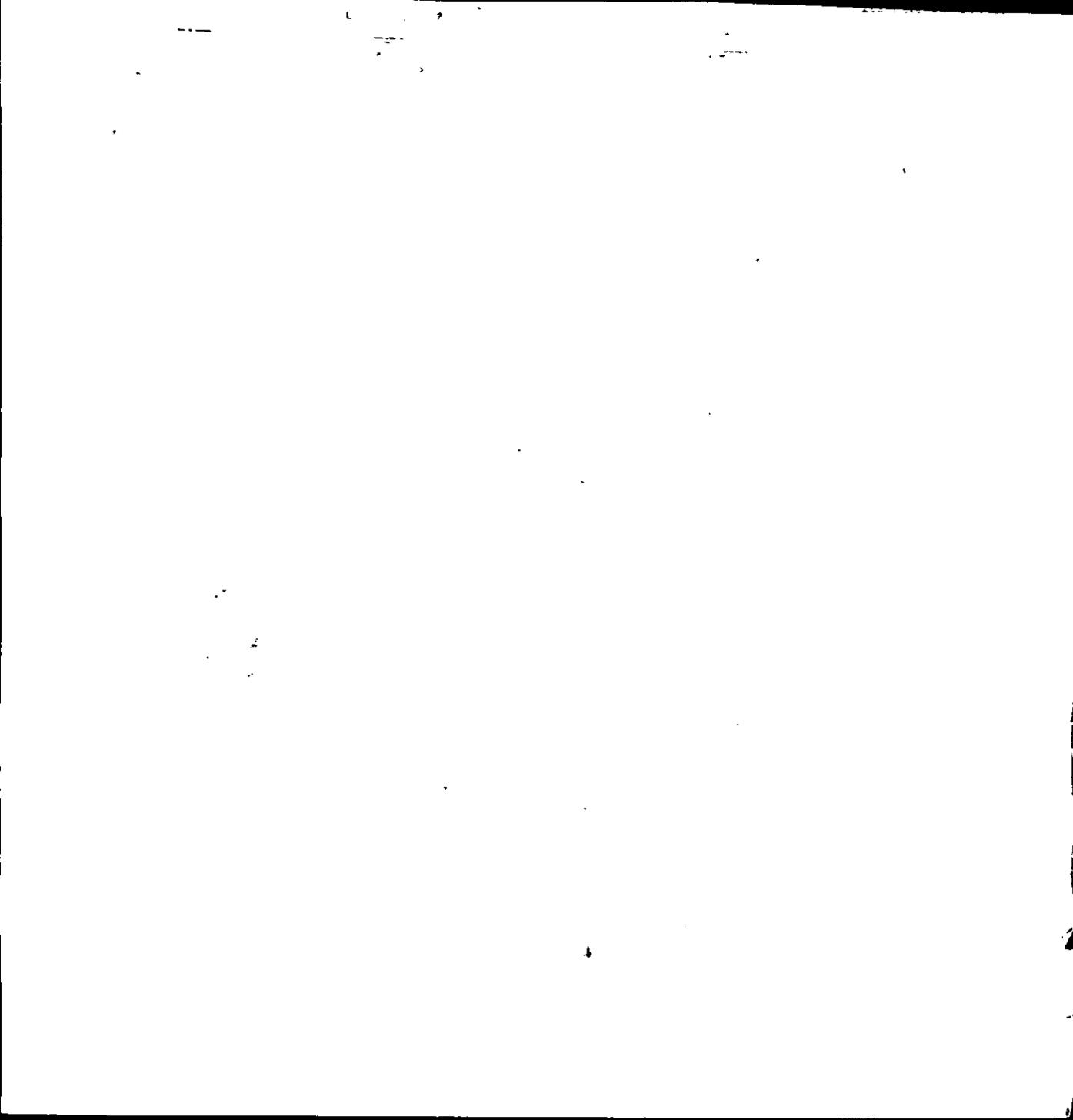
WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) John Dewey M.D.,  
6/20 1928 (Address) Dep. Coroner

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL June 21 19 28

20. UNDERTAKER Benson & Mehan ADDRESS 1138 N 6



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

FOR MUST BE FURNISHED WITH THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County St. Louis Registration District No. 791 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1003 Registered No. 6579  
 City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Anthony Favace  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>15</u>	<u>1</u>	<u>1</u>	<u>1</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 10 11 1928 May C. Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1928

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Shock & injuries  
traumatic amputation  
of left arm & leg  
 (duration) \_\_\_\_\_ mos. ds.  
 CONTRIBUTORY No Acc. Involved  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) J.W. Keener, M.D.  
8/6, 1928 (Address) Dep. Cora

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

COMPLETE AS PREPARED FOR CERTIFICATES UNTIL THE BARS SHALL NOT RE...

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