WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791 .003 File No. 25243

Township..... Primary Registration District No. ..... Registered No. 7040

City..... (No. BARNES Hospital St. ..... Ward)

2. FULL NAME Francis L. Mascheri

(a) Residence. No. 1840 O'Fallon St., 25 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Mascari

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12. 1865

7. AGE: Years 62 | Months 10 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

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) at Home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

PARENTS

10. NAME OF FATHER Salvatore Bono
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy
12. MAIDEN NAME OF MOTHER Annie Corso
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

14. INFORMANT Joseph Mascheri
(Address) 1840 O'Fallon

15. FILED ..... 19.. Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1928

17. I HEREBY CERTIFY, That I attended deceased from 6-29, 1928, to 7-4, 1928 that I last saw her alive on 7-4, 1928, and that death occurred, on the date stated above, at 8 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypertensive heart disease
cardiac decompensation
95B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 90B

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Ekg

(Signed) Robert M. Evans, M.D.
, 19 (Address) Barnes Hospital

*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: July 7 1928

20. UNDERTAKER: Bensiek Mehaus
ADDRESS: 1138 N 6