

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

Do not use this space.

35646

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. 5443 Magnolias)..... St. Ward)

File No.
 Registered No. **10422**

2. FULL NAME Grace Giaravania (Garavagna)

(a) Residence. No. 5443 Magnolias..... St. 13..... 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 Female 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) Oct 17 - 1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than day, hrs. or min.
<u>0</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>✓</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) St. Louis
 (STATE OR COUNTRY)

10. NAME OF FATHER Anthony Giaravania

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

12. MAIDEN NAME OF MOTHER Maria Urzi

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

14. INFORMANT Anthony Giaravania
 (Address) 5443 Magnolias

15. OCT 23 1929 FILED Ray E. Jernigan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 19 29

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1929, to Oct 21 1929 that I last saw her alive on Oct 21 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
119 7 mos gestation
 (duration)..... yrs. mos. 4 ds.
 CONTRIBUTORY SECONDARY none
 (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 symptoms
 (Signed) P. S. Sherman, M. D.
10/22, 1929 (Address) 2212 S. BRIDGEWAY BLDG.

*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 St. Peter - Paul DATE OF BURIAL Oct 22 1929

20. UNDERTAKER Paul E. Calcaterra ADDRESS 1925

K. 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.

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

