

APR 15 1940

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 3225

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS, MO.
(c) Name of hospital or institution: Christian Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days INFANT 65

3. (a) PRINT FULL NAME JAMES BOB VARONE

3. (b) If veteran, name war INFANT 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APR. 6 1940
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | - | - | 1 | hr. min. |

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name: Ferdinand Louis Varone

18. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name: Louise Chsiek

15. Birthplace St. Louis
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ma. Louis Chsiek

(b) Address 5020 Genevieve Ave.

17. (a) BURIAL (b) Date thereof APR. 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW BETHELEM.

18. (a) Signature of funeral director Beddeman Funeral Home

(b) Address 1936 St. Louis Ave.

19. (a) APR 8 1940 (b) J. F. Beddeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 7
(If outside city or town limits, write "RURAL")
(d) Street No. 5020 Genevieve Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR. day 7
year 1940 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from 4-6-40
_____, 19____, to 4-7-40, 19____;
that I last saw him alive on 4-7-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia neonatorum

Due to _____

Due to _____

Other conditions 111
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Halleis (M. D. or other M.D.)
Address 507 St. Louis Ave. Date signed 4-8-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

No embalming

Signed.....

[Handwritten Signature]

Licensed Embalmer No..... *3737*

P. O. Address..... *1936 St. Johns St.*

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, above space should be left blank.