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23159

STANDARD CERTIFICATE OF DEATH  
791 1003

State File No. 30701  
Registrar's No. 7978

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 hrs. 20 mins.  
(Specify whether, \_\_\_\_\_)  
In this community 6 hrs. 20 mins.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 8  
(If outside city or town limits, write "RURAL")  
(d) Street No. 420 Antelope  
0 (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Baby Farace

3. (b) If veteran, name war Newborn 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Newborn

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

7. Birth date of deceased August 30, 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 hr. 20 min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name Tom Farace

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Marjorie Rankins  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ann Morrison

(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 9-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital, No. 1

19. (a) SEP 25 1940 (b) [Signature]  
(Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30,  
year 1940 hour 10:25 minute A.M.

21. I hereby certify that I attended the deceased from September  
August 30, 1940 to September 30, 1940  
that I last saw him alive on September 30, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Prematurity

Due to \_\_\_\_\_

Other conditions (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 [Signature] (M.D. or other) \_\_\_\_\_

Address 1515 Lafayette Ave. Date signed 9/3/40

WRITE PLAINLY—USE 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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**