

Registration District No. 701 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS MO.
(c) Name of hospital or institution ST. LOUIS CHILDRENS HOSPITAL
(d) Length of stay: In hospital or institution 3 DAYS
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County CLAY
(c) City or town FLORA
(d) Street No. 718 E. NORTH AVE
(e) Citizen of foreign country? NO
If yes, name country

3. (a) PRINT FULL NAME WILLIAM F. CASOLARI

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

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

6. (b) Name of husband or wife CHILD 6. (c) Age of husband or wife if alive years 18 1940

7. Birth date of deceased (Month) 8 (Day) 18 (Year) 1940

8. AGE: Years 1 Months 5 Days 16 If less than one day hr. min.

9. Birthplace FLORA, ILLINOIS (City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business

12. Name ALBERT CASOLARI

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

14. Maiden name ALMA RANTZ

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

16. (a) Informant Alma Casolari

(b) Address Floras Ill.

17. (a) REMOVAL (b) Date thereof 3-5-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LITCHFIELD, ILL.

18. (a) Signature of funeral director Albert N. Hopper

(b) Address 4700 Washington

19. (a) FEB 5 1942 (b) J. F. Bredek (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4th year 1942 hour 10:45 P.m. minute M.

21. I hereby certify that I attended the deceased from 2-1-42 1942 to 2-4-42 19

that I last saw him alive on 2-4-42 19 and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoid brain hemorrhage

Due to Toxic Thrombocytopenic purpura

Due to Broncho-pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Bloody Sp. Flu

Of autopsy

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 J. F. Bredek (M. D. or other)

Address 200 N. 1st Date signed

Duration
Physician
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

W. WILKINSON MARY W.

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 W. W. Wilkinson
Licensed Embalmer No. 3575

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.