

FD JUN 19 1943 818
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5972 PAGE BLVD. /
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **000**
17

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL") **9**

(d) Street No. **5972 PAGE BLVD.**
(If rural, give location) **6**

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **ADELE FRANZINI**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **11**
year **1943** hour **11** minute **45** P. M.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **MARCH 18 1887**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 15 1943** to **June 11 1943**
that I last saw him alive on **June 11 1943**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
56 2 23 hr. min.

Immediate cause of death **came in my own death**

Duration _____

Due to _____

Due to _____

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

9. Birthplace **ST. LOUIS MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

MOTHER FATHER { 12. Name **PHILLIP FRANZINI 5**

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

14. Maiden name **JUDITH BEFFA 5**

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant **PHILLIP FRANZINI**

(b) Address **5972 PAGE BLVD**

17. (a) **Burial** (b) Date thereof **6-14-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3846 Bunker Blvd**

19. (a) **JUN 13 1943** (b) **J. F. Bieback**
(Date received local registrar) (Registrar's signature)

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 **Arthur J. Donnelly** (M. D. or other) **MD**

Address **1194 Hodson Ave** Date signed **6-11-43**

Dr. W. W. White
1194 Medicinawalk
1-5
Dr.

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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.