

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED APR 21 1947

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **521**

1. PLACE OF DEATH:

(a) County **Buchanan**

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

(c) Name of hospital or institution: **St. Joseph's Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 hrs. 22 min.**
(Specify whether **Lifetime**)

In this community **Lifetime**
(years, months or days)

3. (a) PRINT FULL NAME **Adam Ambrozi**

3. (b) If veteran, **None** name war

3. (c) Social Security **None** No.

4. Sex **Male** 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 **7** years

7. Birth date of deceased **April 7, 1947**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	0	2 hr. 22 min.

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

10. Usual occupation **None**

11. Industry or business **None**

MOTHER FATHER

12. Name **Martin Ambrozi Jr.**

13. Birthplace **St. Joseph, Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **E. Chicago, Indiana**

15. Birthplace **E. Chicago, Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Martin Ambrozi Jr. (father)**

(b) Address **602 No. 23rd St., City**

17. (a) **Burial** (b) Date thereof **4/9/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Olivet cemetery**

18. (a) Signature of funeral director **John C. Rupp**
(b) Address **6054 Pryor Ave. City**

19. (a) **4-15-47** (b) **B. C. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Buchanan**

(c) City or town **St. Joseph**

(d) Street No. **602 North 23rd Street**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **7** year **1947** hour **9** minute **00** P. M.

21. I hereby certify that I attended the deceased from **Apr 7, 1947** to **Apr 7, 1947** that I last saw him alive on **Apr 7, 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis -**

Due to **Premature**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **159**

Of operations

Of autopsy

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?

(Specify type of place) While at work (e) Means of injury **0**

23. Signature **Frank Hardigan** (M. D. or other)

Address **6703 Francis** Date signed **4/10/47**

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

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.....

Roland W. Clark

Registered Apprentice No. *503*

working under my personal supervision.

Signed.....

John C. Stupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, Mo.*

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.