

FILED MAY 5 1947

1000

575

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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

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:
2704 So. 17th. St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether
 In this community 27 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 2704 So. 17th. St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country *

3. (a) PRINT FULL NAME Ferdinand W. Giannini
 3. (b) If veteran, name war None
 3. (c) Social Security No. 488-14-7995

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 22
 year 1947 hour 1 minute 30 P.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Esther Giannini
 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased August 27 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 23 1947 to April 23 1947
 that I last saw him alive on April 19 1947
 and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 7 Days 25
 If less than one day
 hr. _____ min. _____

Immediate cause of death Prostatic hypertrophy
 Duration unknown

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

Due to _____
 Due to _____

10. Usual occupation Retired Farmer

Other conditions Secondary Anemia
(Include pregnancy within 3 months of death)

11. Industry or business Own

Major findings: Prostatic hypertrophy
 Of operations Prostatic hypertrophy
 Of autopsy 92

12. Name Marion Giannini

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

14. Maiden name Edna Williams

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

16. (a) Informant Mrs. Esther Giannini

(b) Address 2704 So. 17th. St.

17. (a) Burial (b) Date thereof Apr. 24, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Norman W. Sidenfaden

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 4-29-47 (b) W. B. Jenkins
(Date received local registrar) (Registrar's signature)

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? _____ Means of injury _____

23. Signature Wm. Redmond (M.D. or other) MD
 Address 503 Co. Hwy. Bldg., St. Joseph, Mo. Date signed 4/24/47

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.....

James T. O'Connell....., Registered Apprentice No. *486*,
working under my personal supervision.

Signed..... *Robert L. Yapple*.....

Licensed Embalmer No. *3308*.....

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.