

FILED NOV 28 1947

318

Registration District No.

Primary Registration District No.

Registrar's No. **10721**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **ST. Louis, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmiry Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
(c) City or town..... **ST. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal ST.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT-FULL NAME **John Chas. Fazio**
3. (b) If veteran, name war.....
3. (c) Social Security No.

20. DATE OF DEATH: Month **Nov** day **15**
year **1947** hour **6** minute **45 A.M.**

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..... years

21. I hereby certify that I attended the deceased from **7-11**
1947, to **11-15**, 19**47**.
that I last saw him alive on **11-15**, 19**47**,
and that death occurred on the date and hour stated above.
Immediate cause of death. **Transition**
Duration

8. AGE: Years **2** Months **10** Days **26**
If less than one day
hr. min.

Due to..... **Low mentality**
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..... **Nil**

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
Underline the cause of which death should be charged statistically.

11. Industry or business.....
12. Name..... **Chas. Fazio**
13. Birthplace..... **Mass.**
(City, town, or county) (State or foreign country)
14. Maiden name..... **Frances Giamarrico**
15. Birthplace..... **MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **City Infirmiry Records**
(b) Address..... **5800 Arsenal ST.**
17. (a) **Burial** (b) Date thereof **Nov. 17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **calvary**
18. (a) Signature of funeral director..... **P. Miceli & Sons**
(b) Address..... **1150 N. Kingshighway Blvd.**
19. (a) **11/15/47** (b) **J. J. Brueck**
(Date received from informant) (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?.....
(Specify type of place)
While at work?..... (e) Means of injury.....
23. Signature..... **Warren C. News** (M. D. or other)
Address..... **5600 Arsenal** Date signed **11-15-47**

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

MOTHER FATHER

mail

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 _____

Elmer R. Gadwell

Licensed Embalmer No. *4097*

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.