

FILED NOV 28 1947

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10676**

1. PLACE OF DEATH:

(a) County: ST. LOUIS
 (b) City or town: ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
FIRMING O'CONNOR
 (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

3. (a) PRINT FULL NAME ANTHONY REPA
 3. (b) If veteran, _____ 3. (c) Social Security No. _____
 name war.....

4. Sex: MALE 5. Color or race: W
 6. (a) Single, widowed, married, divorced, _____
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased: Nov. 19 - 1947
 (Month) (Day) (Year)

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

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

10. Usual occupation: INFANT

11. Industry or business.....

12. Name: MICHAEL REPA
 13. Birthplace: ST. LOUIS MO
 (City, town, or county) (State or foreign country)
 14. Maiden name: MARGARET M. HALLORAN
 15. Birthplace: ST. LOUIS MO
 (City, town, or county) (State or foreign country)

16. (a) Informant: MICHAEL REPA
 (b) Address: 2826 VICTOR

17. (a) BURIAL (b) Date thereof: Nov 20 - 47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: CALVARY CEM

18. (a) Signature of funeral director: E. J. S. HARR
 (b) Address: 3175 LAFFAYETTE

19. NOV 20 1947 (b) J. A. Cholewick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: new
 (c) City or town: ST. LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 2826 VICTOR
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November day: 20
 year: 1947 hour: 2:30 minute: 0 M.

21. I hereby certify that I attended the deceased from Nov 19 -
19 47 to Nov 20, 1947
 that I last saw him alive on Nov 19, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death: Preterminal & congenital atelectasis

Due to.....

Due to.....

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

Major findings:
 Of operations.....

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?..... (Specify type of place)

23. Signature: R. Berg MD (M. D. or other) 0
 Address: 2253 Nebraska Date signed: Nov 20 1947

PHYSICIAN
 Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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..... *No Embalming*
Licensed Embalmer No.....

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.