

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY 2120	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Royalton Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) R.R. 2 - six miles Jwp	

3. NAME OF DECEASED (Type or Print) a. (First) Frank. b. (Middle) Margheria c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 11-26-1950			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2	8. DATE OF BIRTH 9-27-1875	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner		10b. KIND OF BUSINESS OR INDUSTRY coal		11. BIRTHPLACE (State or foreign country) 5 Italy		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Dominick Margheria		13b. MOTHER'S MAIDEN NAME Madeline unknown		14. NAME OF HUSBAND OR WIFE Josephine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 357-09-7978		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Margheria 4153 Botanical	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma stomach		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4200	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. abdominal carcinomas					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION abdominal cancer.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 151X	

22. I hereby certify that I attended the deceased from 10/25/50, 19, to 11-5/50, 19, that I last saw the deceased alive on 11/24/50, 19, and that death occurred at 11:25 P. m., from the causes and on the date stated above.

23a. SIGNATURE Dean Sauer MD. (Degree or title)		23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 11/27/50.	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-27-1950		24c. NAME OF CEMETERY OR CREMATORY St. Charles		24d. LOCATION (City, town, or county) (State) Royalton/Herrin Illinois	
DATE REGD. BY LOCAL REG. 29 DEC 1950		REGISTRAR'S SIGNATURE J. B. Fasata		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.			

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

-7
L.S.

Handwritten scribble

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *J. Allen Davis Jr*

Licensed Embalmer No. *405-3*

P. O. Address *St. Louis 100*

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.