JAN 27 1939

FEB 7 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3964
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township Normandy — Primary Registration District No. 200 — Registered No. 161
(c) City ~~St Louis County~~ Overland — (d) Street No. 8725 West Place St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME (Maria Torrillo) Maria Isabella Torrillo
(a) Residence, No. 8725 West Place St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ~~Peter~~ Torrillo, Paolo
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 6 1858
7. AGE: YEARS 80 — MONTHS 6 — DAYS 20 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House Wife
9. Industry or business in which work was done, as saw mill, bank, etc.: at Home
10. Date deceased last worked at this occupation (month and year): 6 Mo
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy, ~~Pietroria~~ ~~Pietroria~~ Italy, Pietraroia

FATHER
13. NAME: Pasquale Meglio
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

MOTHER
15. MAIDEN NAME: Zapparelli, Anna
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

17. INFORMANT (ADDRESS): Peter Torrillo, 8725 West Place
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Old St Peter Paul Jan28 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Kriegshauser Und Co, 4228 So Kinghighway Blvd
20. FILED JAN 27 1939 — T. R. Meyer M.D. D.P.H. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan 26 1939, 19
22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12.45 PM
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis Medical Cert. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) John D Connell, M. D.
(Address) Former St Louis County Mo.

Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Corrected Mar 5: 1939 by affidavit L. Wood

See affidavit # 165 in misc file 1939
Dr O. Connell

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 Edwin W McDermott

Licensed Embalmer No. 3024

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis Registration District No.
(b) Township Normandy Primary Registration District No. Registered No.
(c) City (d) Street No. 8725 West Place St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. 8 mos. — ds. — (f) How long in U. S., if of foreign birth? 8 yrs. mos. ds.

2. PRINT FULL NAME Maria Isabella Torrillo
(a) Residence, No. 8725 West Place St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Paolo Torrillo

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
80	6	20	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as saw mill, bank, etc. at Home
10. Date deceased last worked at this occupation (month and year) 6 Months
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pietraroia, Italy

FATHER
13. NAME Pasquale Meglio
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

MOTHER
15. MAIDEN NAME Anna Zapparelli
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy

17. INFORMANT Peter Torrillo
(ADDRESS) 8725 West Place

18. BURIAL, CREMATION, OR REMOVAL
PLACE Old S.S. Pete + Paul DATE Jan. 28 1939

19. FUNERAL DIRECTOR (NAME) Kriegshauser Und Co.
(ADDRESS) 4228 S. Kingshighway Blvd.

20. FILED ....., 19.....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h.... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12:45 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

(Licensed Embalmer's Statement on Reverse Side)

S-3964

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.