

REC'D JUN 1 1939

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

17172
Do not use this space.

791
1008

Registered No. 4706

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No.
(c) City or St. Louis (d) Street No. City Hospital No. 1 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

E. 1866
2. PRINT FULL NAME 156 Baby Cipponeri

(a) Residence, No. 1543 Hogan St. 26
(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 tillborn

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

12. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) St. Louis, Missouri

FATHER 13. NAME Vito Cipponeri
14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) St. Louis, Missouri

MOTHER 15. MAIDEN NAME Billie Day
16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Arkansas

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 5/29/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Van Fossen

20. FILED MAY 24 1939 J. B. ...

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/9/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 5/9/39 to 5/9/39, 19

I last saw him alive on 5/9/39, 19. Death is said to have occurred on the date stated above, at 7.43 a

The principal cause of death and related causes of importance were as follows:

Stillborn

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) H. P. Lattush, M. D.
(Address) City Hospital No. 1

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.

RECORD THIS IS A PERMANENT RECORD

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 comply with the above constitutes grounds for revocation of license.)

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