

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

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.

791
1008
Registration District No. **1008**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None 2815 Dalton av.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2815 Dalton
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 35 years.

3. (a) PRINT FULL NAME

Giovannina Orio 6000

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Angelo Orio

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Feb. 2 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 6 7 hr. min.

9. Birthplace Vargarnara Italy
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 7

11. Industry or business _____

12. Name Ignazio Parisi 7

13. Birthplace Vargarnara Italy 12
(City, town, or county) (State or foreign country)

14. Maiden name Emilia (unknown) 7

15. Birthplace (unknown) Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas R. Brun
(b) Address 51099 Daggert Ave.

17. (a) Burial (b) Date thereof Aug. 12, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthew

18. (a) Signature of funeral director P. Miceli
(b) Address 1150 N. Kingshighway Blvd.

19. (a) AUG 11 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1939 hour 6:40 minutes _____ M.

21. I hereby certify that I attended the deceased from September 1937, 19_____ to August 1939, 19_____
that I last saw her alive on August 9th, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death - Heart failure Duration _____

Due to Chronic Myocarditis
Hypertension & diabetes mellitus
Due to myocarditis

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Peter Cataldi (M. D. or other) _____
Address 4961 Columbia av. Date signed 8/10/39

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

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

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.