

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 784

Primary Registration District No. 115

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7355 Chamberlain
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 57 Years.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7355 Chamberlain Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. 57 years

3. (a) PRINT FULL NAME 52 Angelina Constantino

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Frank Constantino 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 22 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business 7

12. Name Santo Foti 18. Birthplace Italy
(City, town, or county) (State or foreign country)

14. Maiden name Mary Scailzo 15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Constantino

(b) Address 7355 Chamberlain

17. (a) Burial (b) Date thereof Sept 1-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) AUG 31 1939 (b) DR. Murray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29
year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7/14/39
_____, 19____, to 8/29/39, 19____;
that I last saw her alive on 8/28/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach Duration 6 mo.

Due to _____
Due to 4/6 1-0

Other conditions Arteriosclerotic cardio vascular disease
(Include pregnancy within 3 months of death)

Major findings: No operations
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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 _____

28. Signature Estes (M. D. or other)
Address 462 N. Taylor Ave Date signed 8/29/39

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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell*

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

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