

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **1093**
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution: **Missouri Baptist Hospital**
(d) Length of stay: In hospital or institution **Hospital 5 days**
In this community **33 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **4476 Labadie Ave.**
(e) If foreign born, how long in U. S. A. **33** years.

3. (a) PRINT FULL NAME **Vito Orlando**
645
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Dorodia Orlando** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **April 23, 1874**

8. AGE: Years **65** Months **7** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **Terrasini Italy**

10. Usual occupation **Laborer**

11. Industry or business **7**
12. Name **Antonino Orlando**
13. Birthplace **Terrasini, Italy**
14. Maiden name **Angela Cavataio**
15. Birthplace **Terrasini, Italy**

16. (a) Informant's own signature **Ross Orlando**
(b) Address **4476 Labadie**

17. (a) **Burial** (b) Date thereof **Dec. 23, 1939**
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **P. Miceli - Son**
(b) Address **1150 No. Kingshighway Bl.**

19. (a) **DEC 21 1939** (b) _____
(Date received local registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12/20** Day **29** Year _____ hour _____ minute **50 P.** M.

21. I hereby certify that I attended the deceased from **12-15-39** to **12-20-39**; that I last saw him alive on **12-20-39**, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia type I**
Tuberculosis
Due to _____
Due to _____
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? _____
(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 **R. K. Anderson** (M. D. or other) _____
Address **4932 Maryland** Date signed **12/21/39**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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.

1 X1931

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.