

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

Registration District No. 784 Primary Registration District No. 101

1. PLACE OF DEATH: St. Louis  
(a) County 1  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution stillborn  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1  
(a) State Mo. (b) County St. Louis  
(c) City or town Riverview Gardens  
(If outside city or town limits, write "RURAL")  
(d) Street No. 395 Lilac  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Spatafora, Infant Boy 131  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 8  
year 1939 hour 3 minute 20 P. A. M.  
21. I hereby certify that I attended the deceased from 10-8-39  
to 10-8-39, 19\_\_\_\_, to 10-8-39, 19\_\_\_\_;  
that I last saw him alive on stillborn, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 8 1939  
(Month) (Day) (Year)

Immediate cause of death premature separation of placenta  
Duration 10-8-39

8. AGE: Years Months Days If less than one day  
stillborn hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

10. Usual occupation 0

11. Industry or business 9  
12. Name Alex Spatafora  
13. Birthplace ? ?  
(City, town, or county) (State or foreign country)

MOTHER FATHER  
14. Maiden name Jennie Giglie  
15. Birthplace ? La.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Alex Spatafora  
(b) Address 395 Lilac - Riverview Gardens  
17. (a) Cremation (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington & Pathological Dept.

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 \_\_\_\_\_

18. (a) Signature of general director Dr. J. M. ...  
(b) Address Clayton, Mo.  
19. (a) JEC 9-1939 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature Rich Johnston (M. D. or other) \_\_\_\_\_  
Address 1 - Lucas Co. S.W. Date signed 10-17-39

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH SERVICES  
BUREAU OF HEALTH CARE REGULATION  
1000 S. ST. STE. 100  
SACRAMENTO, CALIF. 95833

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**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

445-78  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 101 Registered No. 2161  
 (c) City Clayton (d) Street No. \_\_\_\_\_ 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 Spatofora, Infant Boy  
 (a) Residence, No. \_\_\_\_\_ St.  (if nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
Stillborn

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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)

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

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

17. INFORMANT (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19  
 19. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED 12-9-1939 9 R Meyer, D. P. R. Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8 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 \_\_\_\_\_ 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) Rich Johnston, M. D.  
 (Address) St Louis Co Hosp.

SUPPLEMENTARY

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