

FILED APR 15 1940
Registration District No. 7991

Primary Registration District No. _____

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. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
DePaul Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 days
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Frank Brusca
 (b) If veteran, name war _____
 (c) Social Security No. None

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Angelina Brusca
 (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased Oct. 5 1872
 (Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 24
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

FATHER { 12. Name George Brusca
 13. Birthplace Italy
 (City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Francis Ferrara
 15. Birthplace Italy
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Angelina Brusca
 (b) Address 4943 Palm Street

17. (a) Burial (b) Date thereof 3/2/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Maeger - Ross - Pro, Inc.
 (b) Address 3402 No. Kingshighway

19. (a) MAR 1 1940 (b) _____
 (Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4943 Palm Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
 year 1940 hour 6 minute 30 P. M.
 21. I hereby certify that I attended the deceased from December 1939 to February 28, 1940
 that I last saw him alive on February 28, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Oedema 30 min.
Arterial Chest 10 min.
Acute Cor. Collapse 30 min.
No definite heart disease

Due to 1226
 Other conditions Old operation 2/27/40
 (include pregnancy within 3 months of death)
 for adhesions resulting from old
 Major findings: Pat. operation adhesions
operation for ruptured app.
10 yrs ago.
 Of autopsy no

Duration
30 min.
10 min.
30 min.
 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) no
 (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 A. Henninger (M. D. or other) _____
 Address 105 Dexter Bldg Date signed 2/29/40

Dr. Hueston

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 *Guy W Wilkman*
Licensed Embalmer No. *3575*
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.