

MAY 15 1940
Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3410

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether _____)
In this community yes
years, months or days

3. (a) PRINT FULL NAME Ambrose Aiazzi 200

3. (b) If veteran, name war: NO
3. (c) Social Security No. 489-01-4527

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MALALINA AIAZZI
6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June 22 1879
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 21
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business LABORER

12. Name JOHN AIAZZI

13. Birthplace ITALY
(City, town, or county) (State or foreign country)

14. Maiden name MARIE CALCATERA

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

16. (a) Informant Mike Biaggi

(b) Address 5237 Wilson Ave

17. (a) Burial (b) Date thereof 4-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's

18. (a) Signature of funeral director Paul C. Calcatera

(b) Address 5142 Daguerre

19. (a) APR 15 1940 (b) _____
(Date received for registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 13
(If outside city or town limits, write "RURAL")
(d) Street No. 5237 WILSON AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 25 YEARS years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th
year 1940 hour 4 minute 10 A. M.

21. I hereby certify that I attended the deceased from April 10, 1940, to April 13, 1940; that I last saw him alive on April 13, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Meningitis, pneumococci Type III

Due to Otitis Media

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? _____
(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 Henry J. [unclear] (M. D. or other) _____

Address City Hospital Date signed 4-15-40

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

MOTHER FATHER

Duration

1 wk

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 *Paul C. Colcaterra*.....

Licensed Embalmer No. *2376*.....

P. O. Address *5142 Boygett*.....

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.