

3-40
7-39
X23159

Registration District No. **791**

Primary Registration District No. **1003**

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: **Mo. Valiant Hospital**
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution **6 days**
Specify whether

In this community **7 days**
years, months or days

3. (a) PRINT FULL NAME **Mary Meremonte**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NO**

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Frank Meremonte**

6. (c) Age of husband or wife if alive **51** years

7. Birth date of deceased **Sept. 12 1892**
(Month) (Day) (Year)

8. AGE: Years **48** Months **0** Days **22**
If less than one day

hr. _____ min. _____

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

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **John Merlotti**

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

14. Maiden name **Rose Tacchi**

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

16. (a) Informant **Frank Meremonte**

(b) Address **4924 Botanical**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof **10-7-40**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Alphonsus Cemetery**

18. (a) Signature of funeral director **Frank Calceolaro**

(b) **OCT 5 1940**
(Date received local registrar)

(c) **[Signature]**
(Signature of registrar)

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. **4924 Botanical Ave**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **About 30 Years**
years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **4**
year _____ hour **11** hour minute _____ M.

21. I hereby certify that I attended the deceased from **9/27** 19**40** to **10/4** 19**40**
that I last saw her alive on **10/4** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Essential Hypertension
Chronic interstitial nephritis

Duration **7 days**

Due to _____

Due to _____

Other conditions **19/1**
(Include pregnancy within 3 months of death)

Major findings: _____

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? _____

23. Signature **[Signature]** (M. D. or other) **1**
Address **[Address]** Date signed _____

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

MOTHER FATHER

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 Calaterra

Licensed Embalmer No. *2376*

P. O. Address. *5142 Dagge*

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

If this body is not embalmed, fact should be so stated above.