

**JAN 15 1941 791**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **9904**

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town Kirkwood.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Barrett Station Road.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Adelia M. Ghio.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, married, divorced. Single.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Unknown. 1875  
(Month) (Day) (Year)

8. AGE: Years 65 Months Unknown Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis. Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home. 7

11. Industry or business \_\_\_\_\_

12. Name Anthony J. Ghio. 7

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

14. Maiden name Mary Cuneo. \_\_\_\_\_

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

16. (a) Informant Mrs. Wallace Niedringhaus.

(b) Address 9715 Conway Road.

17. (a) Burial. (b) Date thereof 12-4-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director William J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) DEC 3 1940 (b) J. H. Bredbeck  
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2  
year 1940. hour 12. minute Noon. M.

21. I hereby certify that I attended the deceased from Oct 11  
123 to Dec 2, 1940

that I last saw her alive on Dec 2, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Bronchial Pneumonia 7 days

Due to Bronchial Asthma 20 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1 3/4

23. Signature J. H. Bredbeck (M. D. or other) DEC 3/40

Address 539 N 9th Date signed \_\_\_\_\_

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

5-39 11-10-0  
9-3

**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.....

*W.H. Van Matre*

Licensed Embalmer No.....

*2825*

P. O. Address.....

*4340 Lafayette*

**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.**