

3011  
S. No. 2  
DOM-2-43  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30383

State File No.

8211

FILED SEP 21 1943 318  
Registration District No.

Primary Registration District No. 1003

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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:  
St. Louis City Hospital  
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 2 Days (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

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. 3968 Botanical Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Domnick Sherrillo

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12, year 1943 hour 4:10 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from September 11, 1943 to September 12, 1943 that I last saw him alive on September 12, 1943 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 Married

6. (b) Name of husband or wife Beatrice Sherrillo

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased: April 22, 1876  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

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

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

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>67</u>	<u>4</u>	<u>20</u>	_____ hr. _____ min.

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

10. Usual occupation: Barber

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

12. Name Ferdinand Sherrillo

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

14. Maiden name Lucillia Policastro

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

Major findings: Of operations \_\_\_\_\_

Of autopsy Refused

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Beatrice Sherrillo

(b) Address 3968 Botanical Ave.

17. (a) Burial (b) Date thereof Sept. 17/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl

19. (a) SEP 15 1943 (b) \_\_\_\_\_  
(Date received local register) (Registrar's signature)

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) Means of injury \_\_\_\_\_

23. Signature W. S. Wade (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Avenue, Date signed 9/13/43

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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 *Wm. A. Stewart*

Licensed Embalmer No. 3722

P. O. Address: 412 Duchouquette St.

**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, fact should be so stated above.**