

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33332

State File No. _____

OCT 19 1943

318

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8929

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:
St Johns Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Days
(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. 719 Cole St.
(If rural, give location)

(e) Citizen of foreign country? yes. (Yes or No)
If yes, name country Italy

3. (a) PRINT FULL NAME Margherita Massaro

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased December 13 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

57	9	25	hr. min.
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9. Birthplace Morreale Italy
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Giuseppe Sciortino

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

14. Maiden name Angela Scortino

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

MOTHER FATHER

16. (a) Informant Joe Massaro

(b) Address 719 Cole St. Oct 11 43

17. (a) Burial (b) Date thereof _____
(Date, location, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director P. Micali - Son

(b) Address 1500 N. Kings Highway

19. (a) OCT 9 1943 (b) G. J. Busch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 8 year 43 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9-29-43 to 10-8-43 that I last saw her alive on 10-8-43 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Respiratory Failure

Due to Valvular Heart Disease
Initial Regurgitation chronic

Due to Coronary Artery Hypertension
Pulmonary Hypertension

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 131

Of operations _____

Of autopsy _____

Duration 10 days
2 days

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? _____

Where at work? _____ (Specify type of place)

23. Signature George J. McNamee (M. D. or other) _____
Address 3903 Olive Street Date signed 10-8-43

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

JAN 2 01944

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 *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*.....

P. O. Address *St. Louis, Mo*.....

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.