

35867

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1

Registrar's No. 2442

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS

Registration District No. 317

Primary Registration District No. 3069

No. 2  
1-1-43  
X35597

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 35 years \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4008 Labadie Ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Maria Rosa Danna

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

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

6. (b) Name of husband or wife Paolo 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased November 11 1890  
(Month) (Day) (Year)

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

<u>52</u>	<u>11</u>	<u>20</u>	hr. _____ min.
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9. Birthplace Terrasini Italy  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Dominico Palazzolo

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

14. Maiden name Giuseppa Alfrono

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

16. (a) Informant Tocco Danna

(b) Address 4026 Labadie ave.

17. (a) Burial (b) Date thereof NOV. 3-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Miceli, Son

(b) Address 1150 N. Kingshighway

19. (a) NOV 2-1943 (b) P. W. Mc Gowan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31  
year 1943 hour 5 minute 50 A.M.

21. I hereby certify that I attended the deceased from Oct. 29 1943 to Oct. 31 1943  
that I last saw her alive on Oct. 30 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Left Hemiplegia Duration 2 days

Due to Cerebral Hemorrhage

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

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 8301

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 8

23. Signature J. E. Friedlander M.D. (M. D. or other)

Address 3320 N. Kingshighway Date signed 11-1-43

FEB 3 1953

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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

*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.