. S. No. 2
0M—2-43
5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 22 1943

Registration District No. 918

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 40065

Registrar's No. 10994

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: Christian Hospital 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED: 000

(a) State MO (b) County 17 96

(c) City or town ST LOUIS 9
(If outside city or town limits, write "RURAL")

(d) Street No. 1817 N. 17 str
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME MARY AGNES KALOGEROU (Scopelite)

3. (b) If veteran, name war (~~Scopelite~~)

3. (c) Social Security No. 492-01-4934

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced 3 DIVORCED

6. (b) Name of husband or wife

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

7. Birth date of deceased JAN (Month) 17 (Day) 1896 (Year)

8. AGE: Years 47 Months 10 Days 23 If less than one day hr. min.

9. Birthplace ST LOUIS (City, town, or county) MO 0 (State or foreign country)

10. Usual occupation FAMMOUS BARR

11. Industry or business

FATHER
12. Name SALVATORE SCOPELITE
13. Birthplace ITALY (City, town, or county) 5 (State or foreign country)

MOTHER
14. Maiden name Rosalie Figara
15. Birthplace Italy (City, town, or county) 5 (State or foreign country)

16. (a) Informant Mrs Barbara Zarbo
(b) Address 1817 N. 17 str

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-43 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Mod. Co
(b) Address 1841 Cass ave

19. (a) DEC 13 1943 (Date received local registrar) (b) J. F. Bussick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10
year 1943 hour 7 minute 40 A.M.

21. I hereby certify that I attended the deceased from 11-7-43, 19, to 12-10-, 1943
that I last saw her alive on 12-9-, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Urinary Cancer of bladder

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Cancer of bladder

Of autopsy

Duration: some months

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Andy Hall, Jr. (M. D. ~~or other~~)

Address Dec. 14, 1943 Date signed

(Licensed Embalmer's Statement on Reverse Side) 604 N. Grand - St. Louis

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 Frank Shehan

Licensed Embalmer No. 2915

P. O. Address.....

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.