

Registration District No. **518** Primary Registration District No. **1003**

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:
En Route to City Hospital #1
(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 **Missouri** (b) County **17**
 (c) City or town **St. Louis** **23**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1929 S. 9th. St**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **Dominco Venditto**
 3. (b) If veteran, name war ********* 3. (c) Social Security No. *********

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Unknown**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years **About 60** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Italy** **5**
(City, town, or county) (State or foreign country)
Laborer

11. Industry or business _____
 12. Name **Unknown**
 13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Alfred J. Perry**
 (b) Address **Coroners Office**
 17. (a) **Burial** (b) Date thereof **1-12-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **Petz Brothers**
 (b) Address **3029 Lafayette Ave.**
FEB 12 1944
 19. (a) (Date received local registrar) (b) **J. F. Brudich** (Registrar's signature)
644 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2nd** day **February**
 year **1944** hour **11:40** minute **Am** M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Occlusion
 Due to **Coronary Sclerosis**
W.M.A.
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings:
 Of operations _____
 Of autopsy _____

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)
 (a) Means of injury **9**
 23. Signature **Alfred J. Perry** (M. D. or other)
 Address **Suburban Corona** Date signed **2/12/44**

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

MOTHER FATHER

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.....

.....
working under my personal supervision.

Signed.....

.....
Registered Apprentice No.
.....
Signed *Frank J. Owens*
.....
Licensed Embalmer No. *2245*
.....
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.