S. No. 2
M—2-43
5-17-39
T X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7733

FILED MAR 16 1945 318

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 2114

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

(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)

In this community 25 Years

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. 5057 Beacon Av.
(If rural, give location)

(e) Citizen of foreign country? E.S.L.D. (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME Rosaria (Sarah) Gerace — Gerace, Rosaria (Sarah)

3. (b) If veteran, name war ____

3. (c) Social Security No. 497.07.6406

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Antonino

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

7. Birth date of deceased March (Month) 9 (Day) 1894 (Year)

8. AGE: Years 50 Months 11 Days 23 If less than one day ____ hr. ____ min.

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

10. Usual occupation House Wife

11. Industry or business ____

FATHER
12. Name Matteo Napole
13. Birthplace Castelvetrano (City, town, or county) Italy (State or foreign country)

MOTHER
14. Maiden name Maria Vaina
15. Birthplace ____ (City, town, or county) Italy (State or foreign country)

16. (a) Informant Antonino Gerace
(b) Address 5057 Beacon Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Miceli Sons
(b) Address 1150 N Kingshighway

19. (a) MAR 5 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 2/45 year ____ hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2/1/45 19____ to 3/2/45 19____; that I last saw her alive on 3/2/45 19____; and that death occurred on the date and hour stated above.

Immediate cause of death 1) Cardiac Failure — Coronary thrombosis — Duration 2 days

Due to ____

Due to ____

Other conditions (Include pregnancy within 3 months of death) Following Gall Bladder operation — Cholecystectomy

Major findings: Of operations Cholelithiasis

Of autopsy Same as above — Cystic Kidney

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 A. J. Signorelli (M.D. or other)

Address 2801 N Taylor Date signed 3/2/45

(Licensed Embalmer's Statement on Reverse Side)

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.