

S. No. 2  
DM-5-43  
V. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
U.S. GOVERNMENT PRINTING OFFICE: 1935  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11683**  
Registrar's No. **2931**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town **St. Louis Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**2842 Dalton Ave**  
(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)

3. (a) PRINT FULL NAME **Rosalie Spellazza**  
3. (b) If veteran, name war..... No  
3. (c) Social Security No. **NO**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced, **Widowed**  
6. (b) Name of husband or wife **Samuel**  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **Jan 17 1897**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**49 2 9** hr. min

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

10. Usual occupation **Housework**

11. Industry or business **At Home**

12. Name **Jasper Vicare**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Rose Acinelli**

(b) Address **2842 Dalton Ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3 30 46**  
(Month) (Day) (Year)

(c) Place: burial or cremation **New St. Peter Paul**

18. (a) Signature of funeral director **Kriegshauser**

(b) Address **4228 So. Kingshighway**

19. (a) **MAR 28 1946** (Date received local registrar) (b) **Redeek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **000 77**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **77 13**  
(d) Street No. **2842 Dalton Ave** (If rural, give location) **0**  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **26**  
year **1946** hour **12 Noon** minute **13** M.

21. I hereby certify that I attended the deceased from **12-23-42** 19. to **3/13-46** 19.  
that I last saw **W** alive on **3/13** 19. **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Sudden

Due to **Hyper tension**

Other conditions (Include pregnancy within 3 months of death) **82**

Major findings: Of operations **W**

Of autopsy **W**

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.....

23. Signature **Joseph L. Ferris** (M. D. or other) **3/24/46**  
Address **4061 S - 50th Ave** Date signed **3/24/46**

(Licensed Embalmer's Statement on Reverse Side)

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

10595

MOTHER, FATHER

Dr Ferris

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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 Edwin D Mc Dermott  
Licensed Embalmer No. 3024  
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.