

No. 2
12-45
17-39
X-47070

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8839042

Registration District No. #64635 Primary Registration District No. 1003 Registrar's No. 9707

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1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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:

(a) State MO (b) County Franklin
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5108 Ballou Ave
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12th
year 1946 hour 12:38 minute P M.
21. I hereby certify that I attended the deceased from 11/8/46
to Nov. 12th, 1946
that I last saw her er alive on Nov. 12th, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial infarction from left
coronary artery disease
Due to artery
Due to arteriosclerosis, gangrene years
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
4 days
years

Major findings:
Of operations _____
Autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 _____
Signature Harbert Lafayette Date signed 11/16/46
Address _____ Date signed _____

3. (a) PRINT FULL NAME CARMELLA SAFFO

3. (b) If veteran, name war no 3. (c) Social Security No. 495-16-1943

4. Sex female 5. Color of hair white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Salvatore Saffo 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 8
If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name John Esposito

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

14. Maiden name Concetta Esposito

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

16. (a) Informant Mrs. Saffo

(b) Address 5108 Ballou Ave

17. (a) burial (b) Date thereof Nov 16 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Paul Cafarella

(b) Address 5172 Paggitt Ave
(c) Date received (local registrar) NOV 14 1946 (Registrar's signature) J. F. Baxee

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Elmo R. Cadwell

Licensed Embalmer No. 4077

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.