

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 16 1947**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3413**

Registration District No. **317**

Primary Registration District No. **3269**

Registrar's No. **3652**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **Richmond Hts**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **St. Mary's Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **0**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1424 Blair**  
(If rural, give location)  
(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME

**Baby Orlando**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **single**

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

7. Birth date of deceased **January 2 1947**  
(Month) (Day) (Year)

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

9. Birthplace **St. Louis MO.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business

12. Name **Mr. Peter Orlando**  
13. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Antoniette Candolfo**  
15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Peter Orlando**  
(b) Address **1424 Blair**

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

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **P. Miceli - sons**

(b) Address **1150 N. Kings Highway**

19. (a) **1-4-46** (b) **Ruth Gallin M.D.**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **2** year **1947** hour **12:00** minute **midnight** M.

21. I hereby certify that I attended the deceased from **1-2-47** to **1-2** 19**47**  
that I last saw her alive on **1-2-47** and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy **none**

Duration

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **W. H. White, Jr.** (M. D. or other) **MD**  
Address **624 N. Grand** Date signed **1-3-47**

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

MOTHER FATHER

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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.....

Licensed Embalmer No.....

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.**