U. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947
#69270

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10876

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3043

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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 80 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 25 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1405 Pine Street 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME KATE GINOCHIO

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 single

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan. 27, 1867 (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 22 If less than one day hr. min.

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

10. Usual occupation housekeeper

11. Industry or business self

FATHER
12. Name David Ginochio
13. Birthplace Italy (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rose Soldini
15. Birthplace Italy (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. Collier

(b) Address 1021 Oakwood Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joseph A. Howard

(b) Address 1619 S. Grand Blvd.

19. (a) MAR 21 1947 (Date received local registrar) (b) J. F. Bresek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th year 1947 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from 3/14/47, 19..., to 3/19/47, 19...; that I last saw her alive on 3/19/47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia both lower lobes — Duration

Due to

Due to

Other conditions Paralytic Ileus
(Includes pregnancy within 3 months of death)

Major findings:
Of operations not done

Of autopsy "

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 [illegible] (M. D. or other)

Address 1515 Lafayette Date signed 3/19/47

(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.....

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.