

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No. **22296**
Registered No. **6479**
St. Ward.....

2. FULL NAME

(a) Residence. No. **Anna Rizzo** St. **25** Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **August Rizzo**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 23-1866**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 5 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) **at home**

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Italy**
(STATE OR COUNTRY)

10. NAME OF FATHER **Mario Mercurio**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Italy**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Donna Maria**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Italy**
(STATE OR COUNTRY)

14. INFORMANT **August Rizzo**
(Address) **916 Wash St**

15. **AN 19 1923** **May C Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 17 1928**

17. I HEREBY CERTIFY That I attended deceased from **June 14**, 19**28**, to **June 17**, 19**28**, that I last saw him alive on **June 14**, 19**28**, and that death occurred, on the date stated above, at **2 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy

CONTRIBUTORY (SECONDARY) **Prior stroke of Cerebral Apoplexy**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

C DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **H. F. Doyle** M. D.
19 (Address) **No 819 Washington St.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Calvary

DATE OF BURIAL

June 20 1928

20. UNDERTAKER

Bensiek-Meharis

ADDRESS

1138 N 6

