

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

Do not use this space.

23041

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... St. Louis (No.....)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 6486  
St..... Ward.....

**2. FULL NAME** Rosa Garrozzo

(a) Residence. No. 5235 Elisabeth St. 13 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Single

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** June 9<sup>th</sup> 1931

**17.**

I HEREBY CERTIFY, That I attended deceased from 6/9, 1931, to 6/9, 1931, that I last saw h. alive on 6/9, 1931, and that death occurred, on the date stated above, at 6:45 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Bronchitis

10600 (duration) yrs. mos. 2 ds.

**CONTRIBUTORY (SECONDARY)**

Inanition

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Walt Steinhann, M. D.

6/11, 1931 (Address) 5715 Southwest Ave

\*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.

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb. 27 1931

7. AGE	YEARS			If LESS than 1 day, ..... hrs. or ..... min.
	MONTHS	DAYS		
<u>0</u>	<u>3</u>	<u>13</u>		

**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) -----  
(c) Name of employer -----

**9. BIRTHPLACE (CITY OR TOWN)** St. Louis  
(STATE OR COUNTRY) Mo

**10. NAME OF FATHER** Sam Garrozzo

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

**12. MAIDEN NAME OF MOTHER** Alfia Tomarohio

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

**14. INFORMANT (Address)** Sam Garrozzo  
5235 Elisabeth St.

**15. FILED** 7-1-31 W. C. Stark REGISTRAR

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** St Peter - Paul **DATE OF BURIAL** June 11 1931

**20. UNDERTAKER** Paul Calcaterra **ADDRESS** 5142 Reaggett

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.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 6486  
 City..... (No. 5235, Elizabeth)..... St..... Ward.....

**2. FULL NAME**

*Rosa Garozzo*

(a) Residence No..... S 13 Ward..... (If nonresident give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27-1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work..... (duration)..... yrs. mos. ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) St. Marys, Mo.  
 (STATE OR COUNTRY) St. Louis Co.

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

PARENTS

14. INFORMANT (Address)

15. FILED..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9-1931

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.  
 , 19 (Address)

\*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

5-23041