

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

OCT 23 1935

1. PLACE OF DEATH

County.....

Registration District No.....

791

1003

30986

7778

Township.....

Primary Registration District No.....

File No.....

Registered No.....

City *St. Louis Mo.* (No. *St. John's Hospital*)

St. Ward)

2. FULL NAME *Lucia Caola*

(a) Residence, No. *2705 Park Ave. 27* 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

MEDICAL CERTIFICATE OF DEATH

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 *Silvio Caola*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 1-1895*

7. AGE YEARS *39* MONTHS *10* DAYS *13* If LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *"*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

13. NAME *Dominic Cereghini*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

17. INFORMANT (ADDRESS) *Mrs. Silvio Caola 2705 Park Ave.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery* DATE *Sept 17 1935*

19. UNDERTAKER (ADDRESS) *E. J. Schnur 3725 Lafayette Ave.*

20. FILED *SEP 16 1935* *J. P. Bredeck Registrar.*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 14 1935*

22. I HEREBY CERTIFY, That I attended deceased from *7-14*, 19*35*, to *9-14*, 19*35*.

I last saw her alive on *9-14*, 19*35* Death is said

to have occurred on the date stated above, at *11:55 p.m.*

The principal cause of death and related causes of importance were as follows:

Date of onset

Carcinoma of Cervix

Other contributory causes of importance:

Toxic adenoma of Thyroid

Name of operation *Excisional* Date of *9-9-35*

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury..... 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *Carl Peters*, M. D.

(Address) *4780 Parkway*

