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.

AUG 18 1936

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

Do not use this space.

28865

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7633

City St. Louis, Missouri City Hospital No. 1 ..... St. ..... Ward)

B. 5685

2. FULL NAME Josephone Ricotta

(a) Residence, No. 2231 Cooper St., 13 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: 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: Sam Ricotta

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 18, 1885

7. AGE: 41 YEARS, MONTHS: 4, DAYS: 0. If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

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

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): Italy

FATHER

13. NAME: San ~~Antoine~~ Antinoro

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

MOTHER

15. MAIDEN NAME: Maria Scazza

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

17. INFORMANT (ADDRESS): Hosp. Info. M. H. Kent City Hospital No. 1

18. BURIAL, CREMATION, OR REMOVAL PLACE: Sts Peter & Paul DATE: July 21, 1936

19. UNDERTAKER (ADDRESS): Paul G. Calcatura 5142 Daggett ave

20. FILED: JUL 20 1936 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7/17/36, 19

22. I HEREBY CERTIFY, That I attended deceased from 7/15/36, 19 to 7/17/3, 19

I last saw her alive on 7/17/36, 19 Death is said to have occurred on the date stated above, at 11 p.m.

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

Date of onset

Cerebral Hemorrhage
Pulmonary edema
95b 2

Other contributory causes of importance:

Malignant Hypertension
Cardiac Hypertrophy

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? Yes

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) Thos W. Logan, M. D.

(Address) City Hosp. A 1