

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

36386
Do not use this space.

NOV 15 1937

1. PLACE OF DEATH

(a) County Registration District No. 791
 (b) Township Primary Registration District No. 11008
 (c) City St. Louis (d) Street No. Mo. Baptist Hospital Registered No. 9963 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ramona Certo
 (a) Residence, No. 2720 Park Ave. St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 23, 1928</u>		
7. AGE YEARS <u>9</u>	MONTHS <u>4</u>	DAYS <u>3</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>School Girl</u>		
9. Industry or business in which work was done, as 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) <u>St. Louis Mo.</u>		
13. NAME <u>Antoni Certo</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Italy</u>		
15. MAIDEN NAME <u>Amelia Corradini</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Italy</u>		
17. INFORMANT <u>Antone Certo</u> (ADDRESS) <u>2720 Park Ave.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary Cent.</u> DATE <u>10-28-37</u> 19 <u>37</u>		
19. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u> (ADDRESS) <u>3840 Lindell Blvd.</u>		
20. FILED <u>OCT 27 1937</u> <u>J. T. Predeck</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 26, 1937 1937

I HEREBY CERTIFY, That I attended deceased from Oct 10 1937 to Oct 26 1937
 I last saw her alive on Oct 26 1937. Death is said to have occurred on the date stated above, at 10.15 A.M.
 The principal cause of death and related causes of importance were as follows:

Dissect of Lung (Right)
non I. B. cause unknown

Other contributory causes of importance: 114 lbs

Name of operation None Date of.....

What test confirmed diagnosis? X-Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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? no
 If so, specify.....
 (Signed) Joseph E. Carney M. D.
 (Address) 525 Fried Rd.

James B. Kelly
8-2

STATEMENT BY LICENSED EMBALMER

I, Stanley Marchlewski, Licensed Embalmer No. 2868

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Stanley Marchlewski
Licensed Embalmer No. 2868

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.)