

6860 MAR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

4668
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **1361**
 (c) ^{or} City **St. Louis Mo.** (d) Street No. **St. John's Hospital** 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 **1** yrs. **18** mos. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Sylvia Maino**

(a) Residence, No. **33967 St. Ferdinand Av.** St. **11**
 (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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 23 1938**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 0 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) **St. Louis. Mo.**

13. NAME **Michael M Maino**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Syracuse N. Y.**

15. MAIDEN NAME **Stella Norcia**

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

17. INFORMANT **Michael M Maino**
 (ADDRESS) **3967 St Ferdinand Av.**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Calvary** DATE **Feb. 13 1939**

19. FUNERAL DIRECTOR (NAME) **P. Miceli & Son**
 (ADDRESS) **1150 N Kingshighway**

20. FILED **FEB 11 1939**
J. F. Brudick
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **FEB Jan 11 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 10 1939** to **Jan 11 1939**
 I last saw him alive on **Jan 10/319** Death is said to have occurred on the date above, at **145A**
 The principal cause of death and related causes of importance were as follows:

Broncho pneumonia Date of onset **Jan 10/39**

Other contributory causes of importance:
Congenital Heart Def.

Name of operation..... Date of.....
 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) **Jos P. Costello** M. D.
 (Address) **Staten Island**

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.

Em blank signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Em blank signed
Signed.....
Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.