

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

REC'D SEP 14 1939

Registration District No.

791
1003

Primary Registration District No.

791
1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Faith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution hospital
(Specify whether
In this community six weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 2
(c) City or town Columbia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) INR
(e) If foreign born, how long in U. S. A.? 20 years.

3. (a) PRINT FULL NAME

Filomena DeLuca 420

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

Female

5. Color or race

White

6. (a) Single, widowed, married, divorced

Married

6. (b) Name of husband or wife

Gilardo DeLuca

6. (c) Age of husband or wife if alive

52 years

7. Birth date of deceased

Dec. 27, 1893
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

45

8

3

hr. min.

9. Birthplace

Ginestra
(City, town, or county)

Italy
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

at her home

12. Name

Michele Caggiano

13. Birthplace

Ginestra
(City, town, or county)

Italy
(State or foreign country)

14. Maiden name

Teresa Ichinilla

15. Birthplace

Ginestra
(City, town, or county)

Italy
(State or foreign country)

16. (a) Informant's own signature

Gilardo DeLuca

(b) Address

Columbia, Illinois

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

Sept. 2, 1939
(Month) (Day) (Year)

(c) Place: burial or cremation

Galvary Cemetery

18. (a) Signature of funeral director

P. Muceli + Son

(b) Address

1150 No. Kingshighway

19. (a) SEP 14 1939

(Received local registrar)

J. F. Bredeck
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1939 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug - 1 - 1938 to Aug 30 1939
and that death occurred on the date and hour stated above.
that I last saw her alive on Aug 30 1939

Immediate cause of death: Carcinoma of uterus Duration 2 yrs
Due to _____
Due to _____
Other conditions: Metastatic carcinoma 6 mos
(include pregnancy within 3 months of death)

Major findings: Radum applications on
Of operations: (1 yr ago)
Of autopsy: _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(a) Cause of injury run
23. Signature Charles Whitt (M. D. or other)
Address 508 N. Grand Date signed 8/30/39

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.

Signed Arnold W. Schone

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

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.