

Registration District No. 1000

Primary Registration District No. _____

Registrar's No. 8693

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
821 N. 8th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 years (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME Sylvester Guiffrida

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Angelina Guiffrida 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Sept. 28, 1880
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>59</u>	<u>--</u>	<u>11</u>	hr. _____ min.

9. Birthplace Italy
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Restaurant Prop.

11. Industry or business Catering

12. Name Pietro Guiffrida

13. Birthplace Italy
(City, town, or county) (State or foreign country)

14. Maiden name Rose unknown
(City, town, or county) (State or foreign country)

15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Pete Guiffrida

(b) Address 821 N. 8th St.

17. (a) Burial (b) Date thereof Oct. 12, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of Registrar Francis Dickman
(b) Address 14th Union Blvd

19. (a) Oct 11 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 821 N. 8th St. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1939 hour 11 minute 25 M.

21. I hereby certify that I attended the deceased from see 10-35
_____, 19____, to Oct. 9, 1939
that I last saw him alive on Oct. 6., 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Due to decompensation

Due to General Bedema
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
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) (e) Means of injury _____
23. Signature Flordis Barnett (M. D. or other) _____
Address 18 90 Rg. Exh. Bld. Date signed 10-10-39

Duration 4 yrs.
PHYSICIAN _____
Underline the cause to which death should be charged statistically

WHILE FILLING IN 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.

RECD NOV 13 1939 701

1 X 3511

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 *Larry M. White*

Licensed Embalmer No. *3973*

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.