

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3147

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:  
5230 Elizabeth Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community Yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 13  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5230 Elizabeth Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? About 40 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3<sup>rd</sup>  
year 1940 hour 2 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Mar-9  
1 1936 to April 3<sup>rd</sup>, 1940  
that I last saw her alive on April 3, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Hypertensive Cardio Vascular Disease - - Chronic Myocarditis 4 years  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)<sup>15</sup> (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 Charles Montani (M. D. or other) M.D.  
Address 1926A Marconi ave Date signed 4-4-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3. (a) PRINT FULL NAME Rose Odani 435

3. (b) If veteran, name war No 3. (c) Social Security No. NO

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

6. (b) Name of husband or wife John Odani 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years About 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Italy 7  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife 7

11. Industry or business \_\_\_\_\_

12. Name Victor Tappella 7

13. Birthplace Italy 7  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace 11  
(City, town, or county) (State or foreign country)

16. (a) Informant Mike Odani

(b) Address 5230 Elizabeth ave

17. (a) Burial (b) Date thereof April 6, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Church

18. (a) Signature of funeral director Paul C. Calcutt

(b) Address 5142 Daggert ave

19. (a) APR 4 1940 (Date received local registrar) J. H. [Signature] (Signature)

**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

*Paul C. Calcuterra*

Licensed Embalmer No. *2376*

P. O. Address *5142 Dagger*

**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.**