

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

16938
4416

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
35 years. (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Anthony DiFiore 160

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 Rose DiFiore 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Jan. 18. 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 3 28 hr. min.

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

10. Usual occupation Fruit Dealer 7

11. Industry or business

MOTHER FATHER
12. Name Salvatore DiFiore 9
13. Birthplace Italy
(City, town, or county) (State or foreign country)
14. Maiden name Rosa Rimonda.
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rose Di Fiore
(b) Address 813a Carr St.

17. (a) Burial (b) Date thereof May 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Baruch Niehaus
(b) Address 1431 Union Blvd.

19. (a) MAY 17 1940 (b) J. D. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri. (b) County _____
(a) State _____
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 813a Carr St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1940 hour 9. minute 30 p. M.

21. I hereby certify that I attended the deceased from April 26, 1940 to May 16, 1940
that I last saw him alive on May 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acutt Nephritis Duration 20 days
from chr nephritis

Due to _____
131

Due to _____
Other conditions Erythematous Dermatitis & TBC
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) (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 Thos. A. Dill (M. D. or other) MD
Address 7346a Manchester Date signed 5/17/40

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.

