

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **34263**
Registrar's No. **8960**Registration District No. **791**

Primary Registration District 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: **Firmin Desloge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 wks.**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Vaiola Comporato**

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 **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 4, 1919**
(Month) (Day) (Year)8. AGE: Years **21** Months **7** Days **25** If less than one day _____ hr. _____ min.9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **Calogero Comporato**
13. Birthplace **Licata Italy**
(City, town, or county) (State or foreign country)14. Maiden name **Elinora Capritta**
15. Birthplace **Licata Italy**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Calogero Comporato**
(b) Address **911 Walton Ave.**17. (a) **Burial** (b) Date thereof **Nov. 2, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Calvary Cemetery**18. (a) Signature of funeral director **P. Nicoli - Son**(b) Address **1150 No. Kingshighway**19. (a) **OCT 31 1940** (b) **J. F. Bredbeck**
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **12**
(If outside city or town limits, write "RURAL")
(d) Street No. **911 Walton**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10-29-40** day _____
year _____ hour **6:10 A.M.** minute _____ M.21. I hereby certify that I attended the deceased from **9-9-40**
_____, 19____, to **10-29-40**, 19____;
that I last saw her alive on **10-28-40**, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death **Subacute bacterial endocarditis**
Duration _____

Due to _____

Due to _____

Other conditions **Rheumatic heart disease**
(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) (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) _____ Means of injury _____

23. Signature **Dr. W. H. Hynes** (M. D. or other) _____Address **Firmin Desloge Hosp** Date signed **10-30-40**

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. Schoene

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.