

No. 2
4-13-40
5-17-39
X23 59

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36976**
9249
Registrar's No.

Registration District No. **7911** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **City Hospital**
(d) Length of stay: In hospital or institution _____
In this community **Yes**

MAILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **310 SO. 4th ST.**
(e) If foreign born, how long in U. S. A.? **About 25 Years**

3. (a) PRINT FULL NAME **Caroline De Rubis**

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 **Married**

(b) Name of husband or wife **Alexandero De Rubis** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **March 25 1877**

8. AGE: Years **63** Months **7** Days **15** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **Wife**

12. Name **Carlo Foschi**

13. Birthplace **Italy** (State or foreign country)

14. Maiden name **Maria Baritti** (State or foreign country)

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

16. (a) Informant **Alexandero De Rubis**
(b) Address **310 So. 4th St**

17. (a) **Burial** (b) Date thereof **Nov. 12 1940**
(c) Place: burial or cremation **Colony Cemetery**

18. (a) Signature of funeral director **F. J. Baritti**
(b) Address **5142 Daguerre Ave**

19. (a) **Nov 9 1940** (b) _____
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **9 - 40**
year _____ hour _____ minute **2:45 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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?

(a) Signature of physician **Alfred J. _____** (M. D. or other) _____
(b) Address **_____** Date signed **Nov 9 1940**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Rafael Calaterra

Licensed Embalmer No. *2376*

P. O. Address.....

5142 Daggett

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, fact should be so stated above: