

Registration District No. 547

Primary Registration District No. 3029

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Linnwood
(If outside city or town limits, write "RURAL")
(d) Street No. 116 South 7th St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 years.

3. (a) PRINT FULL NAME Rose Fusco

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 married
6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 12 1892
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 12 If less than one day hr. min.

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

10. Usual occupation Housewife 7

11. Industry of business _____

MOTHER FATHER { 12. Name Joseph Quattrocchi 7

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

14. Maiden name Unknown 9

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

16. (a) Informant Mrs. Michael Capella

(b) Address 116 South Seventh St

17. (a) Burial (b) Date thereof 11 27 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Martin's Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 11-26-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24 P
year 1940 hour 8:05 minute _____ M.

21. I hereby certify that I attended the deceased from Nov-1-40 to Nov-24-40

that I last saw her alive on Nov 23, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Endocarditis
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) (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 [Signature] (M. D. or other) _____

Address [Address] Date signed Nov 25

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 Harold O'Connell

Licensed Embalmer No. 3889

P. O. Address Hannibal 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.