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JAN 8 1941

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2486

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dr. Tiernon's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Days.
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mayme Mazzoni

3. (b) If veteran, name war None

3. (c) Social Security No. None

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 November 6, 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>1</u>	<u>24</u>	hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home.

11. Industry or business _____

12. Name Louis Mazzoni.

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

14. Maiden name Amelia Foppiani

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

16. (a) Informant Louis J. Mazzoni.

(b) Address 7064 Natural Bridge Rd.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Jan. 2, 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Donnell

(b) Address 3840 Lindell Blvd.

19. (a) DEC 31 1940 (b) R. Meyer M.D.
(Date received local transfer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town 5039 Raymond Ave.
(If outside city or town limits, write "RURAL")

(d) Street No. St. Louis, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day December
year 1940 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from Dec. 22, 1940, to Dec. 30, 1940; that I last saw her alive on Dec. 30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Complete occlusion of upper descending colon, near splenic flexure; occluded for 9 days before medical aid was summoned. Great upper abdominal distention and fecal vomiting. Carcinoma of descending colon. Secondary: Toxemia, Dehydration Vomiting, Bladder Anuria, Bowel Occlusion.

Other conditions Toxic Dermatitis, Paraproctitis right Myocardial Failure.

Major findings: Of operations None

Of autopsy None

Duration _____

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 R. Meyer M.D. (M. D. or other) M. D.
Address 3718 Jennings Rd., Pine Lawn Date signed 12-31-40

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

MOTHER FATHER

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 W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.