

Registration District No. 775

Primary Registration District No. 6020-A

Registrar's No. 34

1. PLACE OF DEATH:

(a) County St. Francois  
 (b) City or town Bonne Terre, Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME JOHN VALLO

3. (b) If veteran,  name war \_\_\_\_\_ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna Vallo 6. (c) Age of husband or wife if alive ✓ years \_\_\_\_\_

7. Birth date of deceased June 24 1857  
 (Month) (Day) (Year)

8. AGE: Years 83 Months 10 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Merchant

11. Industry or business \_\_\_\_\_

12. Name John Vallo

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Frank Vallo

(b) Address Bonne Terre Mo

17. (a) Burial (b) Date thereof May 1 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Charles Thudt

(b) Address 313 Parkway, Bonne Terre

19. (a) May 1 41 (b) N. W. Nantkin  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
 (c) City or town Bonne Terre  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Beulah St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28  
 year 1941 hour \_\_\_\_\_ minute 10:10 P.M.

21. I hereby certify that I attended the deceased from Apr. 23, 1941, to Apr. 28, 1941;  
 that I last saw him alive on Apr. 28, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia + h. hemiplegia Duration 7

Due to Chronic cardiovascular-vascular disease

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? Yes

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature H. W. Robber (M. D. or other) MD

Address Bonne Terre, Mo. Date signed 4/30/41

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

932

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**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.....

*C. J. Claywell*

Licensed Embalmer No.....

*3706*

P. O. Address.....

*Bonad Lane 7*

**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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18882

Registration District No. 775

Primary Registration District No. 6020<sup>a</sup>

Registrar's No. 34

1. PLACE OF DEATH

(a) County St. Francois  
(b) City or town Bonne Terre  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME John Vallo  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race W  
6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 | 10 | 4 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal) (Mouth) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 28  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death uremia  
hemiplegia

Due to Chr Cardio rens

Due to Renal Disease

Other conditions hemiplegia was  
(Include pregnancy within 3 months of death)  
due to cerebral hemorrhage

Major findings:  
Of operations hage

Of autopsy \_\_\_\_\_

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?  
(Specify type of place) (e) Means of injury

23. Signature Hue Roebber (M. D. or other) MD

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-18882 7941