

STANDARD CERTIFICATE OF DEATH

30165

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7504**

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Park Lane Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)
 In this community 28 Years

3. (a) PRINT FULL NAME Mamie Frasca

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Lazzaro Frasca 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased October 25, 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>10</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Not known Italy
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name Joseph Galuppi

13. Birthplace Not known Italy
(City, town, or county) (State or foreign country)

14. Maiden name Pasqua Magnonimo

15. Birthplace Not known Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Lazzaro Frasca

(b) Address 5541 Theodore Ave

17. (a) Burial (b) Date thereof 9/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) SEP 17 1941 (b) J. J. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 5541 Theodore Ave
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15th
 year 1941 hour 2:00 PM minute 00 M.

21. I hereby certify that I attended the deceased from 8-30-41
1941 to September 14, 19 41
 that I last saw her alive on September 14, 19 41
 and that death occurred on the date and hour stated above.

Immediate cause of death. Acute dilatation of the heart. Duration _____

Due to Chronic myocarditis.

Due to 139a
 Other conditions non-malignant
(Include pregnancy within 3 months of death)

Major findings:
 Of operations Fibroid of uterus.
Chronic appendicitis and salpingitis.
Cystic ovaries.
 Of autopsy Salpingitis - non-reversal

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. James J. Bredel (M.D. or other) M.D. No. 9-16-41
 Address 4350 Lindbergh St. Louis, Mo. Date signed _____

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

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 *William G. Buchholz*

Licensed Embalmer No. *2110*

P. O. Address *St. Louis*

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.