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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 29 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22298

Registration District No. 184 Primary Registration District No. 200 Registrar's No. 1367

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital D (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months (Specify whether

In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis 47 (If outside city or town limits, write "RURAL")

(d) Street No. 5079 N. Kingshighway 9 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MANISCALCO, MARY ANN

3. (b) If veteran, name war

3. (c) Social Security No. Unknown

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Separated 1

6. (b) Name of husband or wife Sam Maniscalco

6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased May (Month) 1 (Day) 1920 (Year)

8. AGE: Years	Months	Days	If less than one day
22	1	16	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Frank J Carroll Jr
13. Birthplace St. Louis (City, town, or county) Mo O (State or foreign country)

MOTHER
14. Maiden name Abbie Mc Mahon
15. Birthplace St. Louis (City, town, or county) Mo O (State or foreign country)

16. (a) Informant Robert Koch Hospital

(b) Address Rock Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/42 (Month) (Day) (Year)

(c) Place: burial or cremation Calvery Cemetery

18. (a) Signature of funeral director Bromschwig Und. Co.

(b) Address 4746 W. Florrisant

19. (a) JUN 24 1942 (Date received in local registrar) (b) E. S. McGarra M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23rd year 1942 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 10th, 1942 to June 23, 1942 that I last saw her alive on June 23, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis of lungs	9 mo.
Due to	
Due to	
Other conditions Tuberculosis of Larynx (Include pregnancy within 3 months of death)	3 mo.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Herbert C. Sweet (M. D. or other)

Address Robert Koch Hospital Date signed 6/24

767

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 1947

AUG 23 1943

JUL 15 1947

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.

OCT 30 1943

Signed G. W. Wilkerson

Licensed Embalmer No. 3575

P. O. Address .....

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.