

S. No. 2
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5-17-3
-I X29467

19720

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No.
Registrar's No. 5772

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

FILED JUL 3 1943 318

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County: *St Louis Mo*

(b) City or town: *St Louis*

(c) Name of hospital or institution: *Josephine Herpke Hospital*

(d) Length of stay: In hospital or institution: *Hospital*

In this community: *no*

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Mo*

(b) County: *000*

(c) City or town: *St Louis*

(d) Street No.: *5300 Dutton*

(e) Citizen of foreign country? *no*

3. (a) PRINT FULL NAME: **LOUIS LOVALDI**

3. (b) If veteran, name war: *no* 3. (c) Social Security No.: *no*

4. Sex: *male* 5. Color: *white* 6. (a) Single, widowed, married, divorced: *married*

6. (b) Name of husband or wife: *Clara Vincent* 6. (c) Age of husband or wife if alive: *no*

7. Birth date of deceased: *Aug 22 1880*

8. AGE: Years: *62* Months: *10* Days: *0* If less than one day: *no*

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

10. Usual occupation: *Grocer*

11. Industry or business: *Butano Lovaldi*

12. Name: *Italy* (City, town, or county) (State or foreign country)

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

14. Maiden name: *Mrs Louis Lovaldi*

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

16. (a) Informant: *5300 Dutton*

17. (a) Address: *5300 Dutton*

18. (a) Signature of funeral director: *Saul Calcestrina*

19. (a) Date received local registrar: *JUN 24 1943*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *22* year *1943* hour *3* minute *0* P. M.

21. I hereby certify that I attended the deceased from *June 1 1943* to *June 22 1943* that I last saw him alive on *6/22 1943* and that death occurred on the date and hour stated above.

Immediate cause of death: *Canceroma of colon + Post operative pneumonia*

Due to: *I*

Other conditions: *Hb*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *no*

(b) Date of occurrence: *no*

(c) Where did injury occur? *no*

PHYSICIAN
Underline the cause to which death should be charged statistically.

Signature: *L. H. Mallick* (M. D. or other) *MD*
Address: *2608 D. Highway* Date signed: *6/24/43*

2000
0082

all
Hartman
Lafayette

1881
Lafayette

11
11

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

working under my personal supervision.

Registered Apprentice No.

Signed

Paul C. Calcaterra

Licensed Embalmer No.

2376

P. O. Address

5142 Daggett

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.