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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

D OCT 27 1943

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 33452

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9211

1. PLACE OF DEATH:
(a) County St Louis Mo
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2019 Edwards St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2019 Edwards St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME ALFIO RAPISARDO
3. (b) If veteran, name war no
3. (c) Social Security No. 489-10-9859
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosaria Rapisardo
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Mar 11 1882 (Month) (Day) (Year)
8. AGE: Years 61 Months 7 Days 7 If less than one day hr. min.
9. Birthplace Italy (City, town, or county) (State or foreign country)
10. Usual occupation City of St Louis
11. Industry or business Laborer
MOTHER FATHER
12. Name Sebastiano Rapisardo
13. Birthplace Italy (City, town, or county) (State or foreign country)
14. Maiden name Veriera De Rello
15. Birthplace Italy (City, town, or county) (State or foreign country)
16. (a) Informant Sebastiano Rapisardo
(b) Address 2019 Edwards St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1943 (Month) (Day) (Year)
(c) Place: burial or cremation New St Louis Cem
18. (a) Signature of funeral director Paul A Calcaterra
(b) Address 5142 Daggett Ave
19. (a) OCT 20 1943 (Date received local registrar) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18/43 hour 2 minute A. M.
21. I hereby certify that I attended the deceased from Oct 18 19 43 to Oct 17 19 43 that I last saw him alive on and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Thrombosis Left Middle Cerebral | |
| Due to: Embolic Metastatic | |
| Due to: from Carcinoma Stomach | |
| Other conditions (Include pregnancy within 3 months of death): Carcinoma Stomach | |
| Major findings: Of operations: Carcinoma Stomach with metastases in Liver | |
| 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 (M. D. or other) Oct 18/43
Address Dunnavant Clot Rd Date signed

(Licensed Embalmer's Statement on Reverse Side)

**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 G W Wilkinson

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.**