

S. No. 2  
M-2-43  
5-17-39  
I X35627

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 3 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36394

State File No. \_\_\_\_\_

Registrar's No. 10280

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deaconess Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Diana Dolores Godi

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

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced - 0

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

7. Birth date of deceased: November 17, 1943  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

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

MOTHER FATHER  
12. Name Anthony S. Godi  
13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Siemer  
15. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A.S. Godi

(b) Address 608 Garnett Rd.

17. (a) Burial (b) Date thereof Nov. 20 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter & Paul Cem.

18. (a) Signature of funeral director John H. Huber

(b) Address 2630 Gravois Ave.

19. (a) NOV 24 1943 (b) J. F. Pusch  
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. 608 Garnett RD.  
(If rural, give location)  
(e) Citizen of foreign country? - No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19  
year 1943 hour 10 minute 08 P.M.

21. I hereby certify that I attended the deceased from Nov. 17  
1943, to Nov. 19 1943

that I last saw her alive on Nov. 19 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Primitive 6 mo

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

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 0

23. Signature P.B. Capell M.D. or other MD

Address 3284 Larchwood Date signed 11-19-43

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

079

096  
NR 4  
3

MOTHER FATHER

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

159

844

10280

10280

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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..... No Embalming.....

Licensed Embalmer No.....

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.**