

FILED JUL 31 1944

STANDARD CERTIFICATE OF DEATH 1003

State File No. 23507  
Registrar's No. 6492

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
Name of hospital or institution: Firmin Desloge Hospital  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 7 weeks  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Varrone, Gabriele

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 493-05-839

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Rosaria 6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased September 21 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>55</u>		<u>10</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation Labor

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

12. Name Giovanna Battista Varrone  
13. Birthplace Italy  
(City, town, or county) (State or foreign country)  
14. Maiden name Cristina Patrillo  
15. Birthplace Italy  
(City, town, or county) (State or foreign country)

16. (a) Informant Rosaria Varrone

(b) Address 4942 Margaretta

17. (a) Burial (b) Date thereof July 25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Miceli-Sou

(b) Address 1150 N. Kingshighway Blvd.

19. (a) JUL 24 1944 (b) J. F. Bruck  
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4942 Margaretta Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22  
year 1944 hour \_\_\_\_\_ minute 4:00 a.m.

21. I hereby certify that I attended the deceased from 5-29-44  
\_\_\_\_\_, 19\_\_\_\_, to 7-22-44, 19\_\_\_\_;  
that I last saw him alive on 7-22-44, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized debility  
Due to Gonorrhea of the left lung & mediastinum  
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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Robert E. Fox (M. D. or other) \_\_\_\_\_  
Address 1355 So Grand Blvd Date signed 7/24/44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 Arnold W. Schoene  
Licensed Embalmer No. 3864  
P. O. Address St. Louis, Mo

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.