

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29601

FILED OCT 6 1944 818

State File No. _____
Registrar's No. 8383

Registration District No. _____ 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:
4565a Labadie Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 28 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mo
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4565a Labadie Ave.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Giuseppe Manzella

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Francesca 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased March 30 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 5 28 .hr. _____ min.

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Giuseppe Manzella

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

14. Maiden name Grazia Partalotta

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

16. (a) Informant Francesca Manzella

(b) Address 4565a Labadie Ave.

17. (a) Burial (b) Date thereof 10/3/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Miceli - Sons
(b) Address 1150 N. Kingshighway Blvd.

19. (a) OCT 2 1944 J. F. Brewer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 28 year 1944 hour 8 minute 10 M.

21. I hereby certify that I attended the deceased from Sept. 24 1944 to Sept. 28 1944
that I last saw him alive on September 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid
Duration _____

Due to _____
Due to _____

Other conditions Chronic
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 J. F. Brewer (M. D. or other) _____
Address 812 North 1st St. Date signed 9/30/44

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

MOTHER FATHER

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.