

DEPARTMENT OF COMMERCE
BUREAU OF STATISTICS
FILED JAN 27 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **71**
Registrar's No. **442**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2307 Marconi
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **Years** / _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis** **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **39**
(d) Street No. **2307 Marconi**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Maria Bottini**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan**, day **12**
year **1945** hour **10** minute **30** A.M.

4. Sex **Female** / 5. Color or race **White** / 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ambrose Bottini** 6. (c) Age of husband or wife if alive **71** years
7. Birth date of deceased: **8** (Month) **15** (Day) **1876** (Year)

21. I hereby certify that I attended the deceased from **April 29, 1944** to **Jan 12, 1945**
that I last saw her alive on **Jan 12, 1945**
and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **4** Days **27** If less than one day
hr. _____ min. _____

Immediate cause of death: **adenocarcinoma of uterus** **1 yr.**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **H/O**

9. Birthplace **Italy** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

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

11. Industry or business _____
12. Name **Rossi**
13. Birthplace **Italy** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Italy** (City, town, or county) (State or foreign country)

16. (a) Informant **Ambrose Bottini**
(b) Address **2307 Marconi**
17. (a) **Burial** (b) Date thereof **1-15-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New SS. Peter & Paul**

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) _____
(e) Means of injury _____

18. (a) Signature of funeral director **Paul Calcaterra**
(b) Address **5142 Daggett Avenue**
19. (a) **JAN 15 1945** (Date received local registrar's certificate) **J. F. Bredenk** (Registrar's signature)

23. Signature **Charles Montany** (M. D. or other) **MD**
Address **5147 Daggett Ave** Date signed **1-13-45**

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

MOTHER FATHER

JAN 16 1945

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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..... *Paul Colcater*.....

Licensed Embalmer No. **2376**.....

P. O. Address **5142 Daggett Ave**.....

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.