

FILED MAR 5 1945

Registration District No. **3063**

Primary Registration District No. **3063**

Registrar's No. **495**

1. PLACE OF DEATH:

(a) County **St. Louis County**

(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 out day**
(Specify whether years, months or days)

In this community **18 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 96**

(c) City or town **Nauvau**
(If outside city or town limits, write "RURAL")

(d) Street No. **3507 Arcola St.**
(If rural, give location)

(e) Citizen of foreign country? **No**
If yes, name country _____

3. (a) PRINT FULL NAME **Baldi, Louise**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Louis Baldi** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **Aug 8 1906**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
38	6	8	hr. min.

9. Birthplace **Milano Italy 5**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **none**

12. Name **Francesco Bergonzi**

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

14. Maiden name **Silvana Zinogno**

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

16. (a) Informant **self**

(b) Address **3507 Arcola Nauvau**

17. (a) **Burial** (b) Date thereof **Feb. 20/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (c) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiament Ave.**

19. (a) **FEB 20 1945** (b) **E. G. McQuinn MO**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16** year **1945** hour **11:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **7** to **15** 19 **45** to **7-16** 19 **45**

that I last saw h. **in** alive on **7-16-** 19 **45** and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage**

Due to **Cancer of Cervix**

Due to _____

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

Major findings: Of operations _____

Of autopsy **yes**

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** about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Morris Oley M.D.** (M.D. or other) _____

Address **601. Beatrice Clark** Date signed **2/16/45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

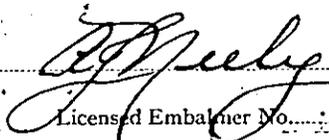
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

6
2
3

AC

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..... 
Licensed Embalmer No..... 3225
P. O. Address..... 1125 Hodiament 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.