

FILED JUN 9 1945  
Registration District No. 318

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 4625

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1321 Hogan Str.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Leona Zarho  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 23rd  
year 1945 hour 11:00 minute 45 M.  
21. I hereby certify that I attended the deceased from 5/20/45  
\_\_\_\_\_ 19\_\_\_\_, to 5/23/45 19\_\_\_\_;  
that I last saw h. or alive on 5/23/45 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Ignazio Zarbo 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

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

8. AGE: abt Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions P. caerulea mellita  
(Include pregnancy within 3 months of death)

9. Birthplace Italy \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
10. Usual occupation House Wife

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

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

16. (a) Informant Ignazio Zarbo  
(b) Address 1321 Hogan str.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 5/26/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery  
Central Und Co.

(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)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 1841 Cass ave  
19. (a) MAY 25 1945 (Date received by Registrar)  
J. F. Bredek (Registrar's signature)

23. Signature E. W. C. ...  
1515 Lafayette (M. P. or other)  
5/23/45 Date signed

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 *John Agorashi*  
Licensed Embalmer No. *3398*  
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.**