S. No. 2
M—5143
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 18 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28426

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1201

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community Res. of St. Louis

2. USUAL RESIDENCE OF DECEASED: ~~City of~~
(a) State Missouri (b) County ~~St. Louis~~
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1831 Madison 9
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3. (a) PRINT FULL NAME Frances DiMarco
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Anthony DiMarco
6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased 9 (Month) 15 (Day) 1892 (Year)

8. AGE: Years 52 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Borgetto, Italy 5
(City, town, or county) (State or foreign country)
10. Usual occupation Dressmaker
11. Industry or business

MOTHER FATHER
12. Name Andrew Migliore 5
13. Birthplace Italy 5
(City, town, or county) (State or foreign country)
14. Maiden name Rosalie Bruno
15. Birthplace Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Rosalie DiMarco-daughter
(b) Address 1831 Madison, St. Louis
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Garfield N. J. ~~New York City, N. Y.~~
18. (a) Signature of funeral director P. P. Micell & Sons
(b) Address 1150 N. Kingshighway Blvd.
19. (a) 8-10-45 (Date received local registrar) (b) E. B. McGowan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9 year 1945 hour 6 minute 05 P. M.
21. I hereby certify that I attended the deceased from 8-4, 1945, to 8-9, 1945; that I last saw her alive on August 9, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Embolism	24 hr
Due to: Gangrene left leg	5 days
Due to: Compound Comminuted fracture	5 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 0 0 0
(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)
While at work? (e) Means of injury 0

23. Signature G. Murphy M.D. (M.D. or other)
Address 601 Brentwood Blvd. Date signed 8-9-45

(Licensed Embalmer's Statement on Reverse Side)

707

MAY 8 1947

AUG 23 1948

DEC 11 1952

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 Ogonowski

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1201

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
(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, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Frances DiMarco

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept 15 (Month) (Day) 59 (Year)

8. AGE: Years 52 Months 10 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

188.5
39

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 8/4/41

(c) Where did injury occur? St Louis County Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place. Fell from horse
(Specify type of place)
While at work? (e) Means of injury

23. Signature G J Murphy MD (M. D. or other)

Address 601 Brentwood Clayton Mo Date signed 8/4/41

5-28426