

U.S. No. 2
FORM-5-43
Rev. 5-17-39
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46940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31890**
Registrar's No. **9211**

FILED NOV 2 1945

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

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

(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**
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **18 days**
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **osc**

(c) City or town **St Louis MO**
(If outside city or town limits, write "RURAL")

(d) Street No. **4535 Shaw Ave**
(If rural, give location)

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

3. (a) PRINT FULL NAME **MARY GALLO**

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

3. (c) Social Security No. **no**

4. **female** 5. Color of race **white**

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

6. (b) Name of husband or wife **August**

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

7. Birth date of deceased **Oct 15 1884**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **23**
year **1945** hour **9:10** minute **A** M.

21. I hereby certify that I attended the deceased from **October 6** 19**45** to **October 23** 19**45**; and that death occurred on the date and hour stated above.

that I last saw h. **or** alive on **October 23** 19**45**

8. AGE: Years **61** Months **0** Days **8** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Domenic Gallo**

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

14. Maiden name **Mary Gallo**

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

16. (a) Informant **M. A. Gallo**

(b) Address **4535 Shaw Ave**

17. (a) **burial** (b) Date thereof **Oct 27 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Peter's Church**

18. (a) Signature of funeral director **Paul C. Calabrese**

(b) Address **5172 Waggott Ave**

19. (a) **OCT 25 1945** (b) **J. J. Predeck**
(Date received local registrar) (Registrar's signature)

Immediate cause of death **Hypertensive Cardiovascular Disease**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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)

Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(d) Means of injury _____

23. Signature **Paul C. Calabrese** (M. D. or other) _____

Address **1515 Lafayette Avenue** Date signed **10/23/45**

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

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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.....

W. W. Wilkins

Licensed Embalmer No..... *3575*

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.