

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
#41-40
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32115**
Registrar's No. **9449**

FILED NOV 10 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... **St. Louis, Mo.**
(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff Memorial
(d) Length of stay: In hospital or institution..... **5mo-21 days**
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **MISSOURI** (b) County..... **000**
(c) City or town..... **ST. LOUIS** (d) Street No..... **1710 S. 8th ST.** (e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME..... **ROSE LOMBARDO**
(b) If veteran, name war..... **NO** (c) Social Security No..... **NO**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... **Oct.** day..... **31st** year..... **1945** hour..... **7:25** minute..... **A** M.
21. I hereby certify that I attended the deceased from..... **5/10/45** to..... **10/31/45** that I last saw him..... **or** alive on..... **10/31/45** and that death occurred on the date and hour stated above.

4. Sex..... **FEMALE** 5. Color or face..... **WHITE** 6. (a) Single, widowed, married, divorced..... **Widow**
(b) Name of husband or wife..... **BAPTISTE LOMBARDO** (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **NOVEMBER 2 1863**
(Month) (Day) (Year)

Immediate cause of death..... **Arteriosclerotic heart disease**
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years..... **81** Months..... **11** Days..... **29** If less than one day..... hr. min.

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

10. Usual occupation..... **NIL**

11. Industry or business.....
12. Name..... **ANTHONY RIZZO**
13. Birthplace..... **ITALY 5**
(City, town, or county) (State or foreign country)

14. Maiden name..... **JOSEPHINE UNKNOWN**
15. Birthplace..... **ITALY 5**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mrs. Margaret Anzerino**
(b) Address..... **1710 S. 8th St.**
17. (a) **BURIAL** (b) Date thereof..... **NOV 2-1945**
(Burial, cremation, or disposal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **CALVARY CEM.**
18. (a) Signature of funeral director..... **E. J. Schmur**
(b) Address..... **3125 Lafayette Av.**

19. (a) **NOV 1 1945** (b) **J. F. Bredenk**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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).....
(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?.....
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature..... **W. W. Wade** (M. D. or other).....
Address..... **1515 Lafayette** Date signed..... **10/31/45**

To: [illegible]

[illegible]

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Signed: [Signature]

Licensed Embalmer No. 4014

P. O. Address: St. Louis Mo

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.