

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED JAN 5 1945 **STANDARD CERTIFICATE OF DEATH**

39500

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11291**

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4518 Tower Grove Place
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 45 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Lola B. Mancini

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 Married

6. (b) Name of husband or wife Francesco Mancini 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased November 18, 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 1 3 hr. min.

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

10. Usual occupation At Home

11. Industry or business At Home

12. Name William Lenox

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

14. Maiden name Armanda Bassett

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

16. (a) Informant Mr. Francesco Mancini

(b) Address 4518 Tower Grove Place

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45
(Month) (Day) (Year)

(c) Place: burial or cremation Our Redeemer Luth. Cem.

18. (a) Signature of funeral director BEIDERWIEDEN, F. HOME, INC.

(b) Address 1936 St. Louis Avenue

19. (a) DEC 24 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 900
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4518 Tower Grove Place
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21st
year 1945 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from 10-15-49 to 12-21-1945
that I last saw her alive on 12-21-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

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) no

(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 [Signature] (M. D. or other) 245
Address 2500 S. Kings Highway Date signed 12-27-45

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

MOTHER FATHER

1-3

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

Delis J. Krissin

Licensed Embalmer No.

3497

P. O. Address

1936 St. Louis

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.