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7. 5-17-39  
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53510  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 438  
Registrar's No. 1094

FILED FEB 13 1946  
318

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... St. Louis, Missouri  
(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..... 2 days  
In this community..... WIFE  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME RONALD INGINI  
3. (b) If veteran..... name war.....  
3. (c) Social Security No.....

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... 8<sup>th</sup> 1945  
7. Birth date of deceased..... DEC 8<sup>th</sup> 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
7 1 23 — hr. — min.

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

10. Usual occupation..... INFANT

11. Industry or business.....

MOTHER, FATHER {  
12. Name..... EMIL INGINI  
13. Birthplace..... CHICAGO ILL  
14. Maiden name..... HELEN MAHL  
15. Birthplace..... ST. LOUIS MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant..... Enil Ingini

(b) Address..... 1502 Monroe St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof..... FEB. 2-1946  
(Month) (Day) (Year)

(c) Place: burial or cremation..... CALVARY CEM.

18. (a) Signature of funeral director..... Brookland Undert Co.  
(b) Address..... 1827 HOGAN STR

19. (a) FEB 1 1946 (Date received local registrar) (b) J. F. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... MISSOURI (b) County..... 000  
(c) City or town..... ST. LOUIS. 26  
(d) Street No..... 1502 MONROE ST 11  
(If rural, give location) (e) Citizen of foreign country?..... NO 7  
(Yes or No) If yes, name country.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January 31,  
year 1946 hour 5:55 minute P M.  
21. I hereby certify that I attended the deceased from January 29  
....., 19 46 to January 31 ....., 19 46  
that I last saw him alive on January 31  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Peritonitis Duration  
Due to..... intestinal obstruction with gasperic  
Due to..... Valvular Deficiency  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: Of operations..... 1/22  
Of autopsy.....  
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).....  
(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..... J. F. Bredeek (M. D. or other) MD  
Address..... 508 N. Grand Date signed 2/1/46

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

Register or Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.**

*Mr. Embalming  
John B. Brookland*