

FILED FEB 13 1945

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 10672

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Josephine Heitkamp Hospital
(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 of days _____

3. (a) PRINT FULL NAME Jennie Spatafora
(b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Alex Spatafora 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 29, 1903
(Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Baton Rouge, Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business:

12. Name Sam Gigilo
13. Birthplace Italy
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Spatafora
(b) Address 9735 Lilac Drive.

17. (a) Burial (b) Date thereof Dec. 11, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Daniel Michales
(b) Address 1431 Union Blvd.

19. DEC 8 1945 (Date received local registrar) J. P. Bredest (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Riverview Gardens
(If outside city or town limits, write "RURAL")
(d) Street No. 9735 Lilac Drive.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7 year 1945 hour 2 minutes 57 A.M.

21. I hereby certify that I attended the deceased from 10.2.45, 19____, to 12.7.45, 19____; that I last saw her alive on 12.6.45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 16 hrs +

Due to Hypertension 2 M.O.F.

Other conditions Chc. Valvular Heart Disease
(Include pregnancy within 3 months of death)

Major findings: ASA
Of operations W.L.
Of autopsy K.
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) _____ (Specify means of injury)
23. Signature John J. Ryan (M. D. or other) M.D.
Address 2602 S. Grand St. Date signed 12/7/45

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

100870

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 *Francis J. Heberis*
.....
Licensed Embalmer No. *2915*
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.