

No. 2
2-45
7-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34868**
Registrar's No. **3085**

Registration District No. **317** Primary Registration District No. **6576**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Halls-Ferry Nursing Home 4**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **25-Months**
In this community **60 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5865 Theodosia Ave.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Antonio Vaccaro**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **M.** (15. Color or race **W.**)
6. (a) Single, widowed, married, divorced **M.**

6. (b) Name of husband or wife **Annie Vaccaro**
6. (c) Age of husband or wife if alive **74** years

7. Birth date of deceased **Nov. 18th., 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	10	29	hr. min.

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

10. Usual occupation **Musician**

11. Industry or business

MOTHER FATHER

12. Name **Phillip Vaccaro**

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

14. Maiden name **Maria Unknown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Miss Rose Vaccaro**

(b) Address **5865 Theodosia Ave.**

17. (a) **Burial** (b) Date thereof **10-21-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **10-21-46** (b) **Arthur J. Donnelly**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **17th.**,
year **1946** hour **4** minute **P.** M.

21. I hereby certify that I attended the deceased from **21** 19**44** to **Oct 18** 19**46**
that I last saw him alive on **Oct 17** 19**46**
and that death occurred on the date and hour stated above

Immediate cause of death **Apoplexy**
Hypertension
Due to **4:30**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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 **Walter Shivers** (M. D. or other)
Address **Lindell Blvd** Date signed **10-28-46**

2739 N. Lincoln
276

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: *William Matre*

Licensed Embalmer No. *28205*

P. O. Address *4340 Lafayette*

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.