

No. 2  
12-45  
-17-39  
X47070

FILED JAN 27 1947

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County ST. LOUIS MO

(b) City or town ST. LOUIS MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
CITY HOSPITAL NO 15  
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 2 hr  
LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 4647 TENNESSEE AVE  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME RALPH COLONNA

(b) If veteran, name war #2

(c) Social Security No. 498-01-0865

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN - 12 -  
65 year 1947 hour 7:45 minute A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the \_\_\_\_\_ and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JUNE 1920  
(Month) (Day) (Year)

Immediate cause of death 1 Occlusion of brain  
2 Pulmonary congestion  
3 Cardiac Hypertrophy  
Chronic Interstitial Nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE:

| Years     | Months   | Days      | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>26</u> | <u>7</u> | <u>10</u> | hr. _____ min. _____ |

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

10. Usual occupation FISHER BODY CO.

11. Industry or business ASSEMBLY LINE

12. Name DOMINICK COLONNA

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

14. Maiden name MARIE RUBANA

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

16. (a) Informant MARIE COLONNA

(b) Address 4647 TENNESSEE AVE

17. (a) BURIAL (b) Date thereof NATIONAL  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation JAN. 15 1947

18. (a) Signature of funeral director Therodutus & Son

(b) Address 2913 N. Chavois Ave

19. (a) \_\_\_\_\_ (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature Patrick E. Taylor (M. D. or other) \_\_\_\_\_  
Address Deputy Coroner Date signed 1-17-47

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

JAN 30 1947

*ml*

**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 *Leo J. Budd*  
Licensed Embalmer No. *3989*  
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.