

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution **310 East Courtois**  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **oas**  
(c) City or town **St. Louis**  
(d) Street No. **2310 E. Courtois**  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **DAISY CONTINI**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex **Female** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Fred Contini** 6. (c) Age of husband or wife **1878**  
7. Birth date of deceased **Unknown** (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan** day **2<sup>nd</sup>** year **1947** hour **8** minute **30<sup>th</sup>**  
I hereby certify that I attended the deceased from **Jan 1st 1947** to **Jan 2<sup>nd</sup> 1947**  
that I last saw her alive on **Jan 1st 1947** and that death occurred on the date and hour stated above.

8. AGE: Years **abt 68** Months Days If less than one day hr. min.  
9. Birthplace **Italy** (City, town, or county) (State or foreign country)  
10. Usual occupation **House wife**  
11. Industry or business **at home**  
12. Name **Unknown** 9  
13. Birthplace **Unknown** 9  
14. Maiden name **Unknown** 9  
15. Birthplace **Unknown** 9

Immediate cause of death **Cerebral Hemorrhage**  
Due to **Hypertension**  
Other conditions **83**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
16. (a) Informant **Paul Contini**  
(b) Address **310 E. Courtois**  
17. (a) (Burial, cremation, or removal) **S.S. Peter Paul** (b) Date thereof **1/10/47**  
(c) Place: burial or cremation **S.S. Peter Paul**  
18. (a) Signature of funeral director **Donnell Wood**  
(b) Address **7420 Michigan**  
19. (a) **JAN 9** (b) **J. Breder**  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_  
(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 **Paul E. Keene** (M. D. or other) **1-7-47**  
Address **7062 Walton** Date signed

**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

*L. C. Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Boss

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 248

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: \_\_\_\_\_

(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 or days

3. (a) PRINT FULL NAME Daisy Contini

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased und  
(Month) (Day) (Year)

8. AGE: att 68 Years Months Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation Styly

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredeek (Registrar's signature) \_\_\_\_\_

(Date received local registrar)

(Registrar's signature)

FEB 5 1947

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

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

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

2355