

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 24 1947**

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

State File No. **11469**  
Registrar's No. **2551**

Registration District No. **318** Primary Registration District No. **1002**

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
909 Tyler  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 40 years. (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County R-10  
(c) City or town St. Louis 2617  
(If outside city or town limits, write "RURAL")  
(d) Street No. 909 Tyler 90  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Veneranda Rota  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife John (Giovanni)  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 4 1862  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month Mar day 9  
year 1947 hour 2 minute 10 P. M.  
21. I hereby certify that I attended the deceased from Mar 1  
1947, to March 9 1947.  
that I last saw her alive on Mar 9 1947.  
and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
84 89 5 hr. min.

Immediate cause of death Pneumonia (hypostatic)  
Due to Ch. myocarditis  
Due to \_\_\_\_\_

9. Birthplace Spezzano Piccolo Italy  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business nil  
12. Name Gaetano Miletì  
13. Birthplace Italy  
(City, town, or county) (State or foreign country)  
14. Maiden name Rosa Monaco  
15. Birthplace Italy  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Peter Rota  
(b) Address 5567 Vernon Ave.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12-47  
(Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery  
18. (a) Signature of funeral director P. Miceli-Sons  
(b) Address 1150 N. Kingshighway  
19. (a) MAR 11 1947 (Date received local registrar) (b) J. F. Prueck (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? \_\_\_\_\_ (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 A. H. Dewing (M. D. or other) MD  
Address 2342 Almond Date signed 3/8/47

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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..... *Anthony J. Miceli*  
Licensed Embalmer No. *4277*  
P. O. Address..... *St Louis Mo*

**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. 218

Primary Registration District No. 1008

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(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) (Specify whether

3. (a) PRINT FULL NAME Veneranda Rota

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 wid

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation nil

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

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

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 \_\_\_\_\_ Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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 \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

APR 1944

11 4109

1226 ok