

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 25 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15365

Registration District No. 318

Primary Registration District No. 1000

Registrar's No. 3992

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:
Park Lane Memorial Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
 (Specify whether
 In this community 20 Years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4522 Clayton Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Fanny Giani Lunetta

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Phillip Lunetta 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 24th 1868
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 5 22 hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Giani

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

14. Maiden name Jenny Giani (nee)

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

16. (a) Informant's own signature Joe Lunetta

(b) Address 4522 A Clayton Ave

17. (a) Burial (b) Date thereof 4-19-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Dornelle

(b) Address 3640 Lindell Blvd

19. (a) APR 17 1947 (b) J. F. Bredek
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th
 year 1947 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from 4-10-1947 to 4-16-1947
 that I last saw her alive on 4-16-1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4/10/47

Due to Hypertension Malignant?

Due to Arteriosclerosis General?

Other conditions Myocarditis, Cha?
 (Include pregnancy within 6 months of death)

Major findings: Of operations None PHYSICIAN _____

Of autopsy None 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) no

(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 Nicholas Natale (M. D. or other) MD

Address 3861 St. Louis Ave Date signed 4/17/47

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... *W H Van Matre*

Licensed Embalmer No. *2825*

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, above space should be left blank.