FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 1 6 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15742 (184)

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No.

1. PLACE OF DEATH:

(a) County

(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: St. Louis City Hospital Max Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Memorial (Specify whether

In this community 0 (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. 7th & MARKET HOTEL (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CHARLES VACCARO

3. (b) If veteran, name war

3. (c) Social Security No. 499-01-7207

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased ABOUT 1888 (Month) (Day) (Year)

8. AGE: Years ABOUT 63 | Months | Days | If less than one day hr. min.

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

10. Usual occupation DAY LABORER

11. Industry or business

MOTHER FATHER

12. Name VACCARO

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

14. Maiden name Unknown

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

16. (a) Informant JOSEPHINE CORZINE

(b) Address 3622 FOLSOM

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-22-47 (Month) (Day) (Year)

(c) Place: burial or cremation OLD ST PETER & PAUL

18. (a) Signature of funeral director Thos. Kutrubes

(b) Address 2906 Kraus

19. (a) APR 22 1947 (Date received local registrar) (b) J. F. Bradock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1947 hour 7:43 minute P.M.

21. I hereby certify that I attended the deceased from 2-4-47, 19..., to 4-19-47, 19...; that I last saw him alive on 4-19-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the middle 1/3 of the Esophagus	
Due to: 0	
Due to: HO	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations Exploratory Thoracotomy - Carcinoma of Esophagus w. metastases

Of autopsy Gastrostomy

PHYSICIAN — Underline the cause of 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? (Specify type of place)

While at work? Means of injury

23. Signature C. A. Park (M. D. or other)

Address 1515 Lafayette Date signed 4-21-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Signed Homer C. Dill

Licensed Embalmer No. 4347

P. O. Address 2406 Grasso

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4434

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)

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

3. (a) PRINT FULL NAME Charles Vaccaro

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 years

7. Birth date of deceased Abt (Month) 1888 (Day) (Year)

8. AGE: Years Months Days If less than one day

Aft 63 hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MAY 9 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK

15742