

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

#87524
 FEDERAL SECURITY AGENCY
 National Office of Vital Statistics
FILED AUG 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24208**
6715

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

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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 **Missouri** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4552 Westminister**
Memorial (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Anthony Dell'Arìa**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Frances Dell'Arìa** 6. (c) Age of husband or wife if alive **47** years
 7. Birth date of deceased **January 6 1891**
(Month) (Day) (Year)

8. AGE: Years **50** Months **57** Days **6** 23 **23**
If less than one day hr. min.

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

10. Usual occupation **Shoemaker**

11. Industry or business _____
 12. Name **Salvatore Dell'Arìa**

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

14. Maiden name **Carmela Vaccaro**
 Birthplace **Italy**
(City, town, or county) (State or foreign country)

Informant **Frances Dell'Arìa**
 Address **4552 Westminister**

7. (a) **Burial** (b) Date thereof **8-2-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

Place: burial or cremation **Calvary Cemetery**
 (c) Signature of funeral director **Albert H. Hoppe**

Address **111 54700 Washington Blvd.**

19. (a) **AUG 10 1948** (b) **J. F. Medsker**
(Date of local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29th**
 year **1948** hour **10** minute **15 P. M.**

21. I hereby certify that I attended the deceased from **7/7/48**
 _____, 19____, to **July 29th**, 19 **48**
 that I last saw him alive on **July 29th**, 19 **48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration _____

Due to _____
 Due to _____

Other conditions **Chronic Osteomyelitis left humerus**
(Include pregnancy within 3 months of death)
secondary anemia

Major findings: _____
 Of operations _____

Of autopsy _____

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 **J. F. Medsker** (b) **Lafayette** (c) **7/30/48**
(Date of registration) (City or town) (State) (Date signed)

PHYSICIAN

 Underline the cause to which death should be charged statistically.

APR 1 1949

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..... *Elmo R. Cadwell*

Licensed Embalmer No..... *4077*

P. O. Address.....

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.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State of Missouri }
County of _____ } ss.

State File No. _____

AFFIDAVIT FOR CORRECTION OF A RECORD Local Registrar's No. 6715

On this 30 day of July, 1948, before me appears _____
Frances Dell' Aria, who, upon her oath, states that the original record of ~~XXXXX~~ death
for Anthony Dell' Aria, ^{died} ~~XXXXX~~ July 29, 1948, in the State of
Missouri, and which was filed at St. Louis, Mo. on 7-30-48, 19____, should be corrected as follows:

Item No. 7 should read January 6, 1898

Instead of January 6, 1891

Item No. 8 should read 50 - 6 - 23

Instead of 57 - 6 - 23

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Frances Dell' Aria Inf Relationship.

4552 Westminster
Present Address.

Subscribed and sworn to before me this 30 day of August, 1948.

My Commission expires ~~1951-07-27~~ 1951-07-27 ~~1951-07-27~~ 1951-07-27
Edna A. Baxter Notary Public.

S-24208