

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6075

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **970**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	17 9
d. FULL NAME OF HOSPITAL OR INSTITUTION 1429 GRATTAN		d. STREET ADDRESS (If rural, give location) 1429 GRATTAN	

3. NAME OF DECEASED (Type or Print) GIOVANNIA - COVA	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JAN. 31 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 21, 1888	9. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months 2 Days 10	IF UNDER 1 HR. Hours 10 Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME LOUIS BERRA	13b. MOTHER'S MAIDEN NAME LOUISE BIANCI	14. NAME OF HUSBAND OR WIFE ACHILLE COVA
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANGELINE VENTURELLA 1429 GRATTAN
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 69 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 19 1948** to **Nov 21, 1949**; that I last saw the deceased alive on **Nov 20, 1949**, and that death occurred at **8:30 a.m.** from the causes and on the date stated above.

22a. SIGNATURE J. B. L. [Signature] (Degree or title) MDU	23b. ADDRESS 2026 109th St. St. Louis, Mo	23c. DATE SIGNED 12/1/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 3 1949	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE RECD BY LOCAL OFFICE FEB 1 1949	REGISTRAR'S SIGNATURE J. B. L. [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Leavitt
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

4 25 - 6 00 P.M.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Leo J. Budde

Signed.....
Student Embalmer

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo.

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.