

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

1. PLACE OF DEATH a. COUNTY 1		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 40 yrs		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4533 Labadie Ave.		d. STREET ADDRESS (If rural, give location) 10 4533 Labadie 0	

3. NAME OF DECEASED (Type or Print) a. (First) Antonino b. (Middle) c. (Last) Vaccaro			4. DATE OF DEATH (Month) (Day) (Year) Sept. 29, 1950		
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5. SEX M 0	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 19, 1886	9. AGE (In years last birthday) 63	10. UNDER 1 YEAR Months	11. UNDER 18 Hrs. Days	12. UNDER 18 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? 5
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13a. FATHER'S NAME Salvatore Vaccaro	13b. MOTHER'S MAIDEN NAME -----	14. NAME OF HUSBAND OR WIFE Marianna Vaccaro
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY 499-01-3198	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sam Vaccaro 651 a Garfield St.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic Myocarditis</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Abscesses of both lungs</i> 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 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>4322</i>
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22. I hereby certify that I attended the deceased from Dec. 1946, to Sept. 24, 1950, that I last saw the deceased alive on 24 Sept. 1950, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>M. A. Delleck M.D.</i>	(Degree or title)	23b. ADDRESS 508 No. Grand	23c. DATE SIGNED 9/29/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 2, 1950	24c. NAME OF CEMETERY OR CREMATORY calvary cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, MO.
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DATE REC'D BY LOCAL REG. SEP 29 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. Miceli 1150 No. Kingshighway
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
X Mon TB cause of nose cord not

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.

Student
Student Embalmer

Signed *Robert M Murray*

Licensed Embalmer No. *3749*

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.