MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22736

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 4948 Botanical St. ..... Ward)

File No. ..... Registered No. 6143

2. FULL NAME Ghiglione Joseph

(a) Residence. No. 4948 Botanical St., ~~24~~ 17 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Massamina Loroni

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 31 - 1858

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
70	5	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

PARENTS

10. NAME OF FATHER John Ghiglione

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

12. MAIDEN NAME OF MOTHER Mary Barodi

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

14. INFORMANT Angelo Ghiglione
(Address) 4948 Botanical

15. FILED 6, 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June - 4th 1929

17. I HEREBY CERTIFY, That I attended deceased from 11/10/28, 19 to 6/4/29, 19 that I last saw him alive on 6/4, 1929, and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage
Cerebral Apoplexy
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis
(duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 74 A.

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm E Jost, M. D.

6/6, 19 9 (Address) 849 Century Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary Cem.	June 8 1929

20. UNDERTAKER	ADDRESS
Paul C. Calcaterra	1921 Cooper St

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Dr Wm. E Jost
Centery Bldg.