

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.

1935

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

Do not use this space.

45179

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St Louis* (No. *Missouri Baptist Hospital*)

File No.....

Registered No. *12337*

2. FULL NAME *John B. Cuneo*

(a) Residence, No. *1159 Walton Ave* St. *17* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widower</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Caroline Cuneo</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 17-1846</i>		
7. AGE	YEARS <i>88</i>	MONTHS <i>11</i>
	DAYS <i>12</i>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Tinner</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>94</i>	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation..... <i>11</i>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Italy</i>		
MOTHER FATHER	13. NAME <i>John Cuneo</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Italy</i>	
	15. MAIDEN NAME <i>Don't Know</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Italy</i>	
17. INFORMANT (ADDRESS) <i>Louis J. Cuneo</i> <i>1159 Walton Ave</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Dalway Cemetery</i> DATE <i>12/31</i> 19 <i>35</i>		
19. UNDERTAKER (ADDRESS) <i>Arthur J. Donnelly</i> <i>3840 E. Del Plank</i>		
20. FILED <i>24</i> 19 <i>35</i> <i>J. N. Bredeck</i> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 28* 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *Dec 7* 19*34*, to *Dec 28* 19*34*

I last saw him alive on *Dec 28* 19*34*. Death is said to have occurred on the date stated above, at *11:00 p.m.*

The principal cause of death and related causes of importance were as follows:

Hypostatic pneumonia

AK. heart

Dyspnea

Other contributory causes of importance:

complete fracture to right femur by fall down stairs

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *Accident* Date of injury *12/2* 19*34*

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *by fall down stairs*

Nature of injury *mentioned above*

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify *Fred Wm Seiber*, M. D.

(Signed) *Fred Wm Seiber*

(Address) *3201 Washington*

RECORDING INFORMATION IS A PERMANENT RECORD

Dr. Treiber
3201 Washington
Ave